DENTAL
REGISTRATION
AND HISTORY

CITY DENTAL P.C.
11 Broadway, Mezzanine level
New York, NY 10004
Tel. 212-425-0505

Date_____ CellPhone_____ Home Phone_____

Name_____ _____ Soc.Sec.#_____
LAST NAME FIRST NAME
Address_____

City_____ State_____ Zip _____
Sex M___ F___ Age ___ Birthdate _____ Single__ Married __ Widowed __ Separated __ Divorced ___
Patient Employed by _____ _____ Business Phone _____
Whom may we thank for referring you?_____
In case of emergency who should we notify?_____

Primary Insurance

Person Responsible for Account_____
LAST NAME FIRST NAME
Relation to Patient_____ ___ Birthdate _____ Soc.Sec.#_____
Address (if different from patient)_____ Phone #_____
City_____ State_____ Zip _____
Person Responsible Employed by _____ Occupation_____
Business Address_____ Business Phone_____
Insurance Company_____ Group #_____

Additional Information

Is Patient covered by an additional insurance? Yes_____ No _____
Subscriber Name_____ Relation to patient _____ Birthdate _____
Address (if different from patient) _____ Phone #_____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone_____
Insurance Company_____ Soc.Sec.# of member_____

Assignment And Release

I, the undersigned, certify that I (or my dependents) have insurance coverage with _____
And assign directly to City Dental P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further authorize City Dental P.C. to share information about my health with other Medical Professionals and laboratories.

Responsible Party Signature Relationship Date