North Dental PC
561 North Avenue
New Rochelle, NY 10801

(914) 235-3636

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name_____ Date of Birth_____ Soc. Sec. #_____

Address_____ City_____ State_____ Zip_____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone # (____) _____ Cell Phone #1 (____) _____ Cell Phone #2 (____) _____

E-Mail_____

Employer_____ Employer Phone (____) _____

Employer Address_____ City_____ State_____ Zip_____

Spouse's or Parent's Name_____ Employer_____ Work Phone (____) _____

Emergency Contact_____ Phone # (____) _____ Cell # (____) _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account_____ Relation to Patient_____

Address_____ Home Phone (____) _____

Date of Birth_____ Currently a patient in our office? ☐ Yes ☐ No

Employer_____ Work Phone (____) _____

E-Mail_____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured_____ Relation to Patient_____

Insurance ID #_____ Date of Birth_____ Soc. Sec. #_____ Date Employed_____

Employer_____ Work Phone (____) _____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Union or Local #_____

Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. Annual Benefit?_____

ADDITIONAL INSURANCE

Name of Insured_____ Relation to Patient_____

Insurance ID #_____ Date of Birth_____ Soc. Sec. #_____ Date Employed_____

Employer_____ Work Phone (____) _____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Union or Local #_____

Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. Annual Benefit?_____

☐ I authorize payments of insurance benefits directly to the doctor otherwise payable directly to me, and

☐ I authorize the doctor to release any information relating to my dental services to my insurance company and I understand I am responsible for all costs of dental treatment.

Patient's Signature _____