

WESTBURYDENTAL

1600 Stewart Ave, Suite 102 Westbury, NY 11590 (516) 683-0888 westburydentalny@gmail.com

PATIENT INFORMATION

Name:	Loot	Birt	hdate:	Ag	e:	
Sex: \square M \square F \square Other SSN:	Last MM/DD/YYYY Driver's License No. and State:					
Cell Phone #:	Contact pre	ferences (circl	e all that apply):	Email	Text	Phone
	•				Text	riione
Marital Status (circle one): Married Single	Widowed	Divorced	Occupation	:		
Home Phone #:	Work Phone #:					
Email:	Where did you hear about us:					
Address:						
Street	City		State		Zip code	
Parent/Guardian Address:						
Parent/Guardian Phone #:	E	mail:				
Emergency Contact Name:	Phone #:					
Relationship to Patient:	Email:					
INSURANCE INFORMATION						
Insurance Company:		Pho	one #:			
D #: Group #:						
Subscriber Name (if different from patient):						
Subscriber Birthdate:	SSN/Member ID:					
Relationship of Patient to Subscriber:						
COMMUNICATION AND RELEASE						
I hereby authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks.						
I acknowledge that I have reviewed the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my Personal Health Information for the purposes of healthcare operations, treatment, and payment activities. I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment. I understand if I miss or cancel an appointment with less than 48hour notice, there will be a failed appointment fee of \$50/hour booked, which I agree to pay before any further appointments can be made.						
I have read and agree to the content, terms, and conditions listed above.						
Patient or Legal Representative Signature				Date		