

GentleDental

290 Ferry Street, Suite B2, Newark NJ 07105 - Telephone: (973) 817-8888 - Fax: (973) 465-1955

www.getsmile.net

Today's Date: ____/____/____

PERSONAL INFORMATION

Patient's full name: _____

SSN: ____/____/____ Date of Birth: ____/____/____ Sex: Male Female

Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Home Phone: ____/____/____ Cell Phone: ____/____/____

Employer: _____ Work Phone: ____/____/____

E-mail: _____

Marital Status: Married Single Other

Legal guardian name (If patient is under age of 18) : _____

How did you hear about this office? TV Radio Print Internet Other

INSURANCE INFORMATION

If you have insurance, please complete the following information:

Insurance company: _____

Primary Insured's Name: _____

Insured's SSN or ID #: _____ D.O.B: ____/____/____

EMERGENCY CONTACT

In case of emergency, who should we contact?

Name: _____ Phone: ____/____/____

Relationship: _____

I understand that I am responsible to pay Gentle Dental for any treatment performed in this office, in case my insurance should neglect payment.

I understand that I am responsible for any outstanding balance. I will also take responsibility for any balances due to any collection agency. If any prosthodontics (Bridges, crowns, dentures) are not able to be completed due to patients missed appointments, the patient will be held responsible.

A fee of \$50 will be charged to the patient's account if cancelation notice is not given 24 hours prior to the appointment.

I authorize Gentle Dental to submit dental claims to my Dental Insurance company in order to get pay for my dental treatment.

**Patient signature
or (Legal guardian if patient is under age of 18)**

Date