Weinstein Dental Group, PLLC

Stephen Weinstein, D.D.S.
Sol Weinstein, D.D.S.

DATE _____

UPDATE _____

PATIENT INFORMATION

Patient _____

Patient Address _____ City _____ State_____ Zip Code _____

Home Phone: _____ Work Phone: _____ Cell: _____

Sex: ☐ M ☐ F Age _____ Birthdate _____ SS#: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Child

Employer's Name, Address, Phone: _____

_____

If minor child, responsible party:

Name: _____ SS#: _____ Birthdate: _____

Address _____ City _____ State_____ Zip Code _____

INSURANCE INFORMATION

Is Patient covered by Insurance? ☐ YES ☐ NO

Policyholder's Name: _____ SS#: _____ Birthdate: _____

Address *(if different from patient)*: _____

Relationship to Patient: _____

Insurance Company Name: _____ Group #: _____

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

Is Patient Covered by Additional Insurance? ☐ YES ☐ NO *(If "YES", please continue below)*

Policyholder's Name: _____ SS#: _____ Birthdate: _____

Address *(if different from patient)*: _____

Relationship to Patient: _____

Insurance Company Name: _____ Group #: _____

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverages and assign directly to **Above Named Dental Entity** all insurance benefits, 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, if applicable.

_____

Responsible Party Signature

Relationship _____ Date _____

PLEASE TURN OVER ☞