

Thank you for selecting Dr. Lawrence Zabner to provide dental care for you and your family.

How did you hear about our office? _____

Patient Information

Date _____ Patient name _____
Last First Middle
Address _____
Street Apt # City State Zip
Home Ph. # (____) _____ Work Ph. # (____) _____ Cell Ph. # (____) _____ Marital Status _____
Soc. Sec. # ____ - ____ - ____ Drivers Lic. # _____ E-mail: _____
Birthdate ____/____/____ Sex M F If a minor, parent's/guardian's name _____
Name of nearest relative not living with you _____ Relationship _____
If full time student, school name _____
School address _____ Ph. # (____) _____
Emergency Contact _____ Ph. # (____) _____

Responsible Party Information

Name _____
Last First Middle
Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Relationship to Patient _____
Residence _____
Street Apt # City State Zip
Mailing _____
Street Apt # City State Zip
How long at address: _____ Home Ph. # (____) _____ Work Ph. # (____) _____ Cell Ph. # (____) _____
Previous address (if less than 3 yrs.) _____
Employer _____ Occupation _____ No. yrs. employed _____
Employer address _____
Spouse's Name _____
Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Work Ph. # (____) _____ Cell Ph. # (____) _____
Employer _____ Occupation _____ No. yrs. employed _____
Employer address _____

Insurance Information

Insured's Name _____ Soc. Sec. # _____ DOB _____ ID # _____
Insurance Company _____ Group # _____
Insurance Co. Address _____ Ph. # (____) _____
Insured's Employer _____ Ph. # (____) _____
Do you have secondary coverage? Yes ____ No ____ If yes: **Please complete the following information.**
Insured's Name _____ Soc. Sec. # _____ DOB _____ ID # _____
Insurance Company _____ Group # _____
Insurance Co. Address _____ Ph. # (____) _____
Insured's Employer _____ Ph. # (____) _____

Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I, _____ and/or _____ hereby authorize the office of
Name of Patient (Parent or Guardian if minor) Name of Insured
Dr. Lawrence Zabner, D.M.D. to affix my name to any and all claims or documents as related to any and all benefits due to me and my dependants
through my employment with _____ I hereby authorize payment of dental benefits otherwise payable to me, directly to the office
Employer
listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my
dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.
To the extent permitted under applicable law, I authorize release of any information related to the claim.

Signature of Insured

Date