YEIN DENTAL GROUP

306 Broad Ave. Ste #2C
Palisades Park, NJ 07650
Tel (201) 461-5171

Date: ____________________________ **Chart ID:** _____________________

PATIENT INFORMATION

NAME: ____ □ Policy Holder □ Responsible Party
First Name Middle Initial Last Name

Address:______________________________ Sex: □ Male □ Female
City:________________State:________Zip:__________ □ Married □ Single □ Divorced □ Separated □ Widowed
Home Phone:_________________________ Date of Birth:_________________________ Age:__________
Work Phone:______________________Ext:___________ Soc. Sec #:_________________________
Cellular Phone:_________________________ Driver's Lic #:_________________________
E-mail:______________________________
Patient Employed by ______________________________ Business Address:______________________________
Occupation ______________________________ City:__________________ State:_________ Zip:___________

Person Responsible for Account

Name: ______________________________ Relationship to Patient: □ Self □ Spouse □ Child □ Other
First Name Last Name

Address:______________________________ Cellular Phone:_________________________
City:________________State:________Zip:__________ Date of Birth:_________________________ Age:__________
Home Phone:_________________________ Soc. Sec #:_________________________
Work Phone:______________________Ext:___________ Driver's Lic #:_________________________

Whom may we thank for referring you? ____
In case of emergency, who should be notified? ______________________________ Phone: ______________________

INSURANCE INFORMATION

Primary Insurance

Name of Insured: ______________________________ Relationship to Patient: □ Self □ Spouse □ Child □ Other
Soc. Sec #: ______________________________ Ins. Company:______________________________
Date of Birth: ______________________________ Address:______________________________
Employer:______________________________ City:__________________State:_________Zip:__________
Address:______________________________ Insurance ID #:_________________________
City:__________________State:_________Zip:__________ Group #:_________________________

Additional Insurance

Name of Insured: ______________________________ Relationship to Patient: □ Self □ Spouse □ Child □ Other
Soc. Sec #: ______________________________ Ins. Company:______________________________
Date of Birth: ______________________________ Address:______________________________
Employer:______________________________ City:__________________State:_________Zip:__________
Address:______________________________ Insurance ID #:_________________________
City:__________________State:_________Zip:__________ Group #:_________________________

ASSIGNMENT AND RELEASE

I, the undersigned certified that I (or my dependent) have insurance coverage with ______________________________
Name of Insurance Company(ies)
and assign directly to Dr.__________________________ all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charged 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.

______________________________ ______________________ ______________________
Responsible Party Signature Relationship Date