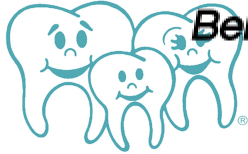

Bergen Premiere Dentistry
245 East Main Street
Ramsey NJ 07446
201-746-4614

Medical Alert for Office Use

Thank you for visiting Bergen Premiere Dentistry. Please help us by completing this form.

Patient Information

Name ____
LAST FIRST Birth date

Address ____
STREET

____
CITY STATE ZIP

Employer ____________________ Social Security # ____________________

Phone: Home

Work ____________________ E-mail ____________________

Mobile ____________________

Emergency: Name ____________________ Phone ____________________

Insurance

Primary Dental Carrier

Subscriber Name ____________________ Social Security # ____________ DOB ________

Insurance Co. ____________________ Relation to patient

____

Secondary Dental Carrier

Subscriber Name ____________________ Social Security # ____________ DOB ________

Insurance Co. ____________________ Relation to patient

____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature ________________________________ **Date** ____________

If Patient is Under 18

Responsible Party Relation to Patient

Other Information

Telephone

How did you hear about us?

What was the reason for today's visit?

Do you love your smile?

Is there anything you would like to change?

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE DATE