



New Patient Information
Adult

Patient's Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ Social Security # \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

May we call you at work? [ ] Yes [ ] No E-mail address \_\_\_\_\_
May we leave a message? [ ] Yes [ ] No

Which dentist will you be seeing in this practice?
[ ] Jeffrey H. Berkowitz, DDS [ ] Steven R. Fischer, DDS
[ ] Gregory C. Chan, DDS [ ] Christopher J. Lupariello, DMD
[ ] Bryan Connolly, DDS [ ] Francois D. Letourneau, DMD
[ ] Brad Turner, DMD

Person financially responsible for the account \_\_\_\_\_ Social Security # \_\_\_\_\_
Date of Birth \_\_\_\_\_

I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to Timberlane Dental Group. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize Timberlane Dental Group to release all information necessary to secure payment. It is my responsibility to pay any deductibles, co-payments and any other fees not paid by insurance. I understand payment is expected at the time of service.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_
(If patient is a minor, a parent or guardian must sign.)

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Name of Dental Insurance \_\_\_\_\_ Address \_\_\_\_\_

Please check which is applicable: Group Insurance [ ] Medicaid [ ]

Name of Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_

Date of Birth (Policy Holder) \_\_\_\_\_ Soc. Security # (Policy Holder) \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Secondary Dental Insurance

Name of Dental Insurance \_\_\_\_\_ Address \_\_\_\_\_

Please check which is applicable: Group Insurance [ ] Medicaid [ ]

Name of Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_

Date of Birth (Policy Holder) \_\_\_\_\_ Soc. Security # (Policy Holder) \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Medical Insurance (required for treatment of dental injuries sustained in an accident)

Name of Medical Insurance \_\_\_\_\_ Address \_\_\_\_\_

Please check which is applicable: Group Insurance [ ] Medicaid [ ]

Name of Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_

Date of Birth (Policy Holder) \_\_\_\_\_ Soc. Security # (Policy Holder) \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_