DR. ELIZABETH J. RESNICK, D.D.S., P.C.

First Name _____ M.I. _____ Last Name _____

Birthday ___/___/___ Soc Sec # _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell Phone # _____

Marital Status: Married / Single / Divorced / Widowed _____ Sex: Male / Female _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone number _____

Who may we thank for referring you here? Name: _____

***********IF PATIENT IS A MINOR, GUARDIANS INFORMATION MUST BE WRITTEN BELOW*************

Person Responsible for this Account: _____ Soc.Sec.# _____

Employer: _____ Occupation _____

Address: _____

City _____ State: _____ Zip: _____ Business Phone: _____

Patient/Guarantor Signature _____ Date: _____ Relationship to Patient: _____

**************************************PRIMARY INSURANCE***

Insurance Company: _____ Group # _____

Subscriber Name: _____ Relationship to Patient: _____

Soc. Sec. # _____ Birthday: ___/___/___ Employer: _____

Employer Address _____ City _____ State _____ Zip: _____

I authorize the dentist to release any information including the diagnosis and records of any treatment rendered to me or my child to third party payers and/or health practitioners. I authorize my insurance company to pay benefits directly to the dentist. Please initial _____

I acknowledge receipt of the Notice of Privacy Practices and consent to their use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. Please initial _____

_____

Patient/Guarantor Signature Relationship to Patient Date