WESTSIDE DENTAL
162 W 72nd St, Suite #2
New York, NY 10023
(212) 496-2260
W72dental@gmail.com

PATIENT INFORMATION

Name: ____ First ____ Last ____ Birthdate: ____ MM/DD/YYYY Age: ____

Sex: ☐ M ☐ F ☐ Other SSN: ____ Driver's License No. and State: ____

Cell Phone #: ____ Contact preferences (circle all that apply): Email Text Phone

Marital Status (circle one): Married Single Widowed Divorced Occupation: ____

Home Phone #: ____ Work Phone #: ____

Email: ____

Address: ____ Street ____ City ____ State ____ Zip code

Parent/Guardian Address: ____

Parent/Guardian Phone #: ____ Email: ____

Emergency Contact Name: ____ Phone #: ____

Relationship to Patient: ____ Email: ____

INSURANCE INFORMATION

Insurance Company: ____ Phone #: ____

ID #: ____ Group #: ____

Subscriber Name (if different from patient): ____

Subscriber Birthdate: ____ SSN/Member ID: ____

Relationship of Patient to Subscriber: ____

COMMUNICATION AND RELEASE

I hereby authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks.

I acknowledge that I have reviewed the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my Personal Health Information for the purposes of healthcare operations, treatment, and payment activities. I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment. I understand if I miss or cancel an appointment with less than 48hour notice, there will be a failed appointment fee of $50/hour booked, which I agree to pay before any further appointments can be made.

I have read and agree to the content, terms, and conditions listed above.

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Patient or Legal Representative Signature Date