Keith Silverman DMD

40 West 86th Street, Suite 1A, NY, NY 10024

PERSONAL: Date: ____/____/____

First Name: _____ Last Name: _____

SS#: _____ DOB: ____/____/____ Sex: ☐ F ☐ M

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____

Cell #: _____ Email: _____

Occupation: _____

Employer: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____ Cell #: _____

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Medical Doctor: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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INSURANCE INFORMATION:

Health Insurance: _____

Policy #: _____ Group #: _____

Insured's Name (If Different): _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Self-Pay ☐ Yes ☐ No

MEDICAL INFORMATION:

Reason For Visit: _____

Current Health And Medical History: _____

_____

Have you ever had complications following dental treatments?

_____

Medications (Including herbal supplements and vitamins):

_____

_____

_____

Allergies: _____

Smoker: ☐ Yes ☐ No Number of cigarettes per day: _____ Alcohol: ☐ Yes ☐ No

HOW DID YOU HEAR ABOUT US?

Reference Name: _____ Relationship: _____

Find us online? ☐ Google ☐ Yahoo ☐ Yelp ☐ ZocDoc

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FINANCIAL AGREEMENT

(Required)

I understand that my insurance benefits may not provide coverage for all fees associated with my (patient/parent or guardian) dental treatment. It is my responsibility to know and understand my insurance benefits and coverage policies.

I agree to be responsible for any non-covered services rendered to me or my dependent.

I agree to pay for fees not covered by insurance, including but not limited to co-payments and deductibles established by the insurer.

_____ _____

Signature of Patient (Parent or Guardian) Date