ALLAN K. BERNSTEIN, DDS

PATIENT INFORMATION SHEET

Name: _____ Date: _____

Address: _____ City: _____ State & Zip: _____

Social Security Number: _____ Marital Status: ○ Married ○ Single ○ Other

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Birthdate: _____ Age: _____ Sex: ○ Male ○ Female

Guardian's Name (if minor) _____ Relationship to patient: _____

Drivers License Number _____ Occupation: _____

Employer: _____

Employer Address: _____

Name of Spouse: _____ Spouse's Date of Birth: _____

Spouse's Social Security Number: _____ Employer: _____

Please list the names of two people we may contact in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name of Primary Care Physician: _____ Phone: _____

Address of Primary Care Physician: _____

Date of last physical exam: _____ Referred by: _____ Phone: _____

I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS, HOWEVER, I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE COMPANY BENEFITS BE PAID ON MY BEHALF TO THIS OFFICE FOR ANY SERVICES PROVIDED BY THIS PHYSICIAN. I UNDERSTAND MY SIGNATURE REQUESTS PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF ITEM 9 OF HCFA-1500 IS COMPLETED, MY SIGNATURE AUTHORIZES RELEASING THE INFORMATION TO THE INSURER OR AGENCY SHOWN.

SIGNATURE: _____ DATE: _____