

Neil Salesky, DMD
Michael Reisman, DDS
15-3 Cornerstone Court
Plantsville, Connecticut 06479



Date: _____

Patient Name: _____ Social Security #: _____

Preferred Name: _____ Gender: M F Date of Birth: ___/___/___ Age: ___ Marital Status: _____

Address: _____ Home Phone: () _____
Street Apt/Bldg

City: _____ State: _____ Zip: _____ Email Address: _____

Drivers License #: _____

Employer Name / Address: _____

Occupation: _____ Business Phone: () _____ Cell Phone: () _____

Spouse's Name: _____ DOB: ___/___/___ Soc. Sec. # _____

Spouse's Employer Name / Address: _____

Spouse's Occupation: _____ Business Phone: () _____ Ext. _____

Whom may we contact in case of emergency? _____
Name Relationship Phone

IF PATIENT IS A MINOR OR STUDENT:

Responsible Party: _____ Home Phone: () _____
Name Relationship

Address: _____ Business Phone: () _____

IF PATIENT IS A STUDENT:

Name of School / College: _____ City: _____ State: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Secondary Insurance: _____

Subscriber's Name: _____ Subscriber's Name: _____
(The person employed by the company) (The person employed by the company)

Social Security #: _____ DOB: ___/___/___ Social Security #: _____ DOB: ___/___/___

Address: _____ Address: _____
(If different than patient) (If different than patient)

ID#: _____ ID#: _____

Employer: _____ Employer: _____

SIGNATURE ON FILE

AUTHORIZATION TO PAY BENEFITS:

I hereby authorize payment directly to the above named dentist(s) of the dental benefits otherwise payable to me.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health card, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

These authorizations are valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter.

Patient's Signature

Date