Mitchell Rubinstein D.M.D. Today's Date_____

Patient Information Form

Name_____ Date of Birth_____
Last Middle First

Address _____

City_____State _____ Zip_____

CONTACT INFORMATION

Mobile/Text #_____Home phone_____Work Phone_____

E-mail (***Please PRINT***) ___

Check Appropriate Box ☐ Minor ☐ Single ☐ Married

Occupation_____

Whom may we thank for referring you to our practice? _____

Person to contact in case of an emergency_____ Phone _____

Parent or Responsible Party (*only if different from above*)

Name of person responsible for this account_____ Relationship to patient _____

Address _____ Home phone_____

Birth Date_____

Employer _____ Work phone _____

Are you currently a patient in our office? [ ] Yes [ ] No

We Are Happy To Assist You With Your Dental Insurance

It is important for you to know that we treat all our patients as individuals, according to *your* health needs, and not on the basis of your insurance coverage.

We will gladly provide you with insurance forms for you to submit to your insurance company, along with any needed documentation or X-rays. We will provide any assistance you need to obtain reimbursement for the cost of your dental care.

Whether you submit your insurance forms yourself, or we do it for you, you are responsible for any portion of the fee not covered by your benefit plan. Your signature below also acknowledges receipt of our HIPAA notice of privacy practices.

Signature of patient (or guardian, if minor) X_____Date_____