NORMAN D. JACOBSKIND, DDS PC

PROFESSIONAL DENTAL SOLUTIONS

New Patient Intake

Contact Information

Last name _____ First name _____ Middle initial _____ Date of birth _____
Address _____ City _____ State _____ Zip _____
Home phone ( ) - Cell phone ( ) - Work phone ( ) -
E-mail _____ S.S. number _____ Gender _____
Occupation _____ Employer _____
Work Address _____ City _____ State _____ Zip _____
Emergency contact _____ Relationship _____ Phone number ( ) -
How did you hear about us? _____

Responsible Party (if patient is a minor)

Last name _____ First name _____ Middle initial _____ Date of birth _____
Address (if different) _____ City _____ State _____ Zip _____
Home phone ( ) - Cell phone ( ) - E-mail _____

Insurance Information

Primary Insurance *(if applicable)*

Insurance company _____
Insurer address _____
Subscriber name _____
Relationship _____ Date of birth _____
Insurance ID _____ Group number _____

Secondary Insurance *(if applicable)*

Insurance company _____
Insurer address _____
Subscriber name _____
Relationship _____ Date of birth _____
Insurance ID _____ Group number _____

Please present your insurance card to be photocopied for our records

Authorization

Treatment, Release of Information, and Payment I consent to the diagnostic procedures and dental treatments performed by my dental care providers. I authorize the release of my (or my dependent's) protected health information to other medical/dental practitioners collaborating on my (or the dependent's) care. I also authorize the release of this information to any other entity, as needed, to evaluate insurance benefits and to pursue claims. I agree to allow my insurance benefits to be paid directly to my dentist, and I understand that my insurance benefits may not pay the full bill for services. I accept financial responsibility for any services not paid by my insurance benefits, and for any balance carried on my account. I also understand that my insurance policy may require a copayment and/or deductible, which may not be known at the time of service, but for which I am personally responsible.

Electronic Communications I consent to receiving HIPAA-compliant electronic communications (i.e. via e-mail or text message) regarding my treatment and account, and that standard messaging/data rates may apply. I understand that I am under no obligation to receive these messages and may opt out at any time by following the instructions provided in the electronic message, or by contacting my dentist's office.

The information I have provided on this page is accurate, to the best of my knowledge.

_____ _____
Signature (of parent/guardian, if under 18) Date

400 Merrifield Avenue
Oceanside, NY 11572

Phone: (516) 766-7400
Fax: (516) 766-0020