Alan I Rosenfeld DDS

Centre for Cosmetic & Implant Dentistry
93 Route 303
Tappan, NY 10983

Phone: 845-359-1770 **Fax: 845-359-2798**

PATIENT INFORMATION

GENERAL INFORMATION

Mr. Ms. Mrs. Miss Dr.:

____
First Middle Initial Last

If above is a minor, name of parent / guardian:
____

Address:
____
City:_______________________________________State:___________ Zip:_________

Phone: H______________________ W1________________ W2__________________

E-mail:____

DOB:__________________________ SSN:__________________________________

Sex: M F

Full time Student
Where?____

Employer: ____________________________ Occupation: ______________________
Address:
____
City:____State:________ Zip:______

Marital Status: S M D W Name of spouse/partner:____________________

DENTAL PLAN INFORMATION

Primary person insured: None Self Spouse Parent Other

Policy Holder's Employer: ________________________________ Phone: __________
Address:
____
City: ____ State: ______ Zip: ______

Insurance Company: ______________________________________ Phone: __________
Address:
____
City:____State:_____ Zip:_________

Plan Name: ________________________________ Group #:_________________________

ID/SSN:____________________

EMERGENCY CONTACT

Name:__________________________________ Relationship to Patient: ______________
Phone: H_____________________ W1_________________ W2_____________________

I authorize the release of information required for processing.

Signature _______________________________________ Date ___________________