FAMILY & COSMETIC DENTISTRY
DAVID ROMISHER, D.M.D.
7 West Park Avenue, Merchantville, NJ 08109
(856) 663-4510 FAX (856) 663-5852

GENERAL PATIENT AND INSURANCE INFORMATION

DATE _____

Name _____

Address _____

City/State _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security Number _____

Relationship to Insured _____

Insured's Name _____

Insured's Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security Number _____

Insured's Employer/Address _____

Insurance Carrier Name/Address _____

Group Number _____ Identification Number _____

I authorize the health care provider named above to submit claims for payment for services to the health care service plans or insurance companies named above, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services.

I understand that I am financially responsible for any charges not covered by the group insurance benefits and I am financially responsible for all charges if I cannot supply the provider with proper insurance identification.

The office reserves the right to assess late fees and interest to delinquent accounts and balances due on accounts not paid in a timely manner.

I have received the **NOTICE OF PRIVACY PRACTICES** and I have been provided an opportunity to review it.

X

Signature of Patient, Parent, or Guardian Date