Welcome to the Office of - A. JAY CITRIN, D.D.S.

PATIENT INFORMATION

(This will be kept confidential. Please print.)

Patient Name____ Male ☐ Female ☐ Birthdate____________
(Last) (First) (Middle)

☐ Single ☐ Married (Spouse's Name ____________________ Birthdate ____________) ☐ Widow ☐ Divorced ☐ Separated

Residence Address____________________ CITY ____________ ZIP ____________

Phone (______) ____________ Cell Phone (______) ____________ E-mail ____________

Driver's License No.____________ Social Security No. ____________

Employed by ____________ Occupation ____________

Business Address ____________ City, Zip ____________ Phone ____________
A/C Ext.

Spouse Employed by____________ Occupation ____________

Spouse's Business Address____________ City, Zip____________ Phone____________
A/C Ext.

PERSON RESPONSIBLE FOR ACCOUNT

Name____________ Relationship ____________ Soc.Sec.No.____________
(If different from above)

Residence Address ____________ City, Zip ____________ Phone ____________
A/C Ext.

IN CASE OF EMERGENCY CONTACT

Name of Nearest Relative____________ Relationship____________
(Other than Spouse)

Address ____________ City, Zip____________ Phone ____________
A/C Ext.

WHO REFERRED YOU TO US? (We wish to thank them)____________
(Name) (Address)

DENTAL INSURANCE INFORMATION

This information is necessary to make sure you receive the maximum benefits that you are entitled to. Thank you.

Employee's Name ____________ Soc. Sec. No. ____________

Name of Insurance Co. or Union ____________ Group or Union No. ____________

Address ____________ City, State, Zip ____________

If patient is covered by more than one dental insurance, please complete the following:

Name of Spouse ____________ Soc. Sec. No. ____________ Relationship ____________

Name of Insurance Co. or Union ____________ Group or Union No. ____________

Address____________ City, State, Zip____________

AUTHORIZATION TO PAY BENEFITS TO DENTIST

I hereby authorize payment directly to the above dentist for the surgical and/or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Signature ____________ **Date** ____________

TERMS & CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A finance charge of 1½% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within (5) days of billing if credit shall be extended.

I grant my permission to you, or to your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed: ____________ **Date** ____________

PLEASE COMPLETE BOTH SIDES!