



Jerry M. Rosenberg, DMD
6 Half Acre Road
Jamesburg, N.J. 08831

Welcome to our office. Please provide us with the following information.

Personal Information

Name _____ Date of Birth _____
Address _____ S.S.# _____ - _____ - _____
Home Phone _____ Cell Phone: _____
Employed By _____ Work Phone: _____
E-mail address _____
Can we call you at work? Yes No Occupation: _____
Spouses Name _____ Married Single Widowed Divorce
Did someone refer you to our office? _____
Do you have dental insurance? Yes No Does your spouse? Yes No

Who will be responsible for the bill? _____
Signature of responsible party: _____

Dental History

Prior Dentist _____ Date of last checkup? _____
Address _____ Telephone # _____

Insurance

Insured's Name _____ Date of Birth _____
Insurance Company _____ Insured's SS# _____ - _____ - _____
Policy # _____ Group # _____
Address _____ Phone # _____
Employer _____
Coverage - Family Single

Our Insurance Policy – Our office will submit your dental treatment on your behalf. If you wish, you can assign the insurance benefits to our office. **ANY CO-PAYMENTS AND DEDUCTIBLES ARE PAID AT EACH VISIT.** If you do not wish to assign benefits, we will submit your dental treatment on your behalf, however, payments for the treatment are expected at each office visit. I hereby authorize payment directly to Dr. Jerry M. Rosenberg, 6 Half Acre Road, Jamesburg, N.J. 08831.

Our Appointment Cancellation/Rescheduling Policy – It is our office policy that our patients advise us 48 hours prior to their scheduled appointment time if the appointment needs to be cancelled or rescheduled. This gives our office enough time to give that valuable time to another patient in need of dental care. If the appointment cancellation is not advised within 48 hours prior to the appointment, our office may charge a cancellation fee. A “last minute” cancellation fee will be applied to your account based on the amount of time lost. We appreciate your cooperation.

Signature _____ **Date** _____