FAY DENTISTRY
BIOMIMETIC | AESTHETICS | OCCLUSION

16 Old Riverhead Road
Westhampton, NY 11978
631.288.9000

REGISTRATION

Patient Name: _____
Last First MI (Preferred)

Birthdate: _____ Social Security #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Phone (Home): _____ (Work): _____ (Cell): _____

Email Address: _____

Preferred Contact Method: ☐ Home ☐ Work ☐ Cell ☐ Text ☐ Email

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Whom may we thank for referring you to our practice? _____

If not referred by a patient, please let us know how you heard about us? _____

Emergency Contact Information:

Name: _____

Phone #: _____ Relationship to Patient: _____

Insurance Information:

Primary Insurance Carrier: _____

Insurance Company Phone #: _____ Group #: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Name: _____ Subscriber's ID # or SSN: _____

Subscriber's Birthdate: _____ Subscriber's Employer Name: _____

Do you have secondary insurance? ☐ YES ☐ NO If yes, please fill out the sections below.

Secondary Insurance Carrier: _____

Insurance Company Phone #: _____ Group #: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Name: _____ Subscriber's ID # or SSN: _____

Subscriber's Birthdate: _____ Subscriber's Employer Name: _____

Consent for Services:

I authorize the dentist to perform diagnostic and dental procedures as may be necessary for proper dental care and as agreed upon. I have read the above conditions and agree with their content. I will assume responsibility for fees associated with these procedures. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information.

_____

Patient/Guardian Signature Relationship to Patient Date