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_____________