Eden Baluyot Vincent, D.M.D., LLC

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West Orange, NJ 07052
Tel. (973) 731-0087 Fax (973) 731-0024

Patient Information

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's Information

Name: _____ _____ _____ Birthdate:_____/_____/_____
(First) (M.I.) (Last)

Home phone: (_____)_____ -_____ Cell: (_____)_____ -_____ Email: _____

Address:_____ City: _____ State:_____ Zip: _____

Sex: □ M □ F Marital status: □Single □ Married □ Divorced □ Separated □ Widowed SSN: _____-_____-_____

Employer or School: _____ Phone: (_____)_____-_____

Address:_____ City: _____ State:_____ Zip: _____

Person to contact in case of emergency: _____ Phone: (_____)_____-_____

How did you learn about our practice or whom may we thank for referring you? _____

Dental Insurance Information

Insurance company: _____ Phone: (_____)_____-_____

Address:_____ City: _____ State:_____ Zip: _____

Subscriber: _____ _____ Birthdate:_____/_____/_____ SSN: _____-_____-_____
(First name) (Last name)

Relationship to patient: _____ Group #: _____ ID #: _____

Secondary Insurance

Insurance company: _____ Phone: (_____)_____-_____

Address:_____ City: _____ State:_____ Zip: _____

Subscriber: _____ _____ Birthdate:_____/_____/_____ SSN: _____-_____-_____
(First name) (Last name)

Relationship to patient: _____ Group #: _____ ID #: _____

Authorization and Release

- I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.
- I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for service.
- **I agree to be responsible for payment of ALL services rendered on my behalf or my dependents.**
- I understand that payment is due at the time services are rendered which includes deductibles and copays.

_____ Date:_____/_____/_____

Patient or Guardian Signvature