ARLINGTON ADULT DENTISTRY

dedicated to excellence

☐ Dr. Ryan Springer
☐ Dr. Sergio Rubinstein
☐ Dr. Daniel Czapek

Date: ____________________

Patient Information (Section A)

☐ Dr. ☐ Mrs. ☐ Mrs. ☐ Ms. Patient Name ____
(First) (Last) (MI)

Date of Birth: _______/_______/_______ Marital Status: ☐ S ☐ M ☐ D ☐ W Preferred Name ________________

Address: ____ How Long: ____________
(Number) (Street) (Apt#) (City) (State) (Zip)

Primary Phone Number: (______) _______ - _______ ☐ Home ☐ Cell ☐ Work ☐ Other______________

Secondary Phone Number: (______) _______ - _______ ☐ Home ☐ Cell ☐ Work ☐ Other______________

Email Address: ____ Preferred method of contact? ☐ Call ☐ Text ☐ Email

Employer Name: ______________________________________ Occupation: _________________________________

How long with this employer?______________ Emergency Contact Name: ____________________________________

Phone Number:_____________________________ Realationship: ____

Whom may we thank for referring you? ____

Responsible Party (Section B) *If same as above, skip to Section C*

Name ____ Date of Birth: _______/_______/_______
(First) (Last) (MI)

Relationship to patient ____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Address: ____ How Long: ____________
(Number) (Street) (Apt#) (City) (State) (Zip)

Primary Phone Number: (______) _______ - _______ ☐ Home ☐ Cell ☐ Work ☐ Other______________

Second Phone Number: (______) _______ - _______ ☐ Home ☐ Cell ☐ Work ☐ Other______________

Email Address: ____

Dental Insurance Information (Section C)

Name of Policy Holder ____ DOB ______/______/______
(First) (Last) (MI)

Social Security Number: ________-________-________ Relationship to Patient: __________________________

Member ID Number: ______________________________________ Group Number: ______________________

Employer Name: __________________________________ Insurance Company: __________________________

Insurance Address: __________________________________ Insurance Phone Number: (______) _______ - _______

If you carry a secondary dental plan, please provide information below:

Name of Policy Holder ____ DOB ______/______/______
(First) (Last) (MI)

Social Security Number: ________-________-________ Relationship to Patient: __________________________

Member ID Number: ______________________________________ Group Number: ______________________

Employer Name: __________________________________ Insurance Company: __________________________

Insurance Address: __________________________________ Insurance Phone Number: (______) _______ - _______

HIPAA Acknowledgement

Receipt Acknowledgement of Notice of Privacy Practie ____
(Initials) (Date)

Consent for Use & Disclosure of Health Information ____
(Initials) (Date)

*I am 18 years or older and a student. I give permission to contact my parent(s)/legal guardian to discuss dental treatment and all related information ____
(Initials) (Date)

Your signature states information provided is accurate and true: ______________________________
(Signature of Patient or Legal Guardian/Responsible Party)

Updated 10/01/24