

Debra L. Cederbaum, D.D.S.

Welcome! Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

### Patient Information

Legal Name: \_\_\_\_\_ Preferred Name \_\_\_\_\_  
First MI Last  
Preferred Gender Pronouns (i.e. she/her, he/him) \_\_\_\_\_ Date: \_\_\_\_\_ DOB \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail \_\_\_\_\_ Circle One: Single Married Separated Divorced Widowed Partner  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Do you prefer to receive calls at: \_\_\_ Home \_\_\_ Work \_\_\_ Cell \_\_\_ E-mail Sex: M / F  
You or your parent's employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Spouse's or parent's name: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Person to contact in case of emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Responsible Party

Name of person responsible for this account? \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

### Insurance Information

<i>Primary</i>		<i>Secondary</i>	
Name of insured: _____	Relationship to patient: _____	Name of insured: _____	Relationship to patient: _____
Employer: _____	Employer: _____	DOB: _____	ID#: _____
DOB: _____	ID#: _____	DOB: _____	ID#: _____
Insurance Company _____	Program/Group # _____	Insurance Company _____	Program/Group# _____
Claims Address _____	Phone # _____	Claims Address _____	Phone # _____

### Referral Information

\_\_\_ Dental Office \_\_\_ Yellow Pages \_\_\_ PPO List \_\_\_ Current Patient \_\_\_ Web Site \_\_\_ Other  
Name of person or office referring you to our practice: \_\_\_\_\_

**Permit for treatment and surgical care:** I hereby grant permission to the staff of Debra L. Cederbaum, DDS to employ such established treatment therapy as may be deemed professionally necessary and advisable.  
**Financial Agreement:** All charges for services will be paid upon completion of appointment. All outstanding balances shall accrue interest at the rate of 18% per annum. This is in addition to reasonable attorney fees, court cost, and collection agency expenses not to exceed 50% of the amount due at the time of assignment.  
**If insurance is involved:** I hereby authorize payment directly to Debra L. Cederbaum, DDS of group benefits otherwise payable to me. I authorize credit inquires deemed necessary in connection with my account.  
**Cancellation Policy:** There will be a \$45 charge for all canceled or failed appointments without 48 hours notice.

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