NEIL R. CORNELL DDS

Welcome To Our Practice!

Please take a few minutes to answer the following questions
so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate_____

Name _____ Home Phone _____ Cell Phone _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip_____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Seperated

Employer _____ Business Phone _____ E-mail _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____ Relationship to Patient _____
Last Name First Name Initial

Birthdate_____ Soc. Sec # _____ Home Phone _____

Address _____ City _____ State _____ Zip_____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____ Relationship to Patient _____
Last Name First Name Initial

Birthdate_____ Soc. Sec. # _____ Home Phone _____

Address _____ City _____ State _____ Zip_____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

ASSIGNMENT AND RELEASE

I hearby authorize payment directly to Dr. Neil Cornell for all insurance benefits otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Please complete reverse side