

PRINCETON DENTAL GROUP

**Princeton Shopping Center
301 N. Harrison St., Suite F**

Princeton, NJ 08540

609-924-0796

Fax 609-924-7166

Date _____

Name _____ Birth Date _____

Address _____ City/State _____ Zip _____

Telephone Home _____ Work _____ Cell _____

Preferred Name _____

Marital Status _____ Social Security # _____ E-mail address _____

Employed by _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Students: School _____ Major _____ Graduation Yr _____

Name of Spouse/Parent _____

Address (if different from above) _____

How did you hear about us? _____ Referred by _____

Do you have Dental Insurance? Yes _____ No _____ If yes:

Name of Policy Holder _____ Relationship _____

Name of Policy Holder's Employer _____

Date of Birth of Policy Holder _____

Policy ID# _____ Group # _____

Name of Dental Insurance Co. _____

Address of Insurance Co. _____

City _____ State _____ Zip Code _____

Please list all family members covered under this policy _____

I authorize release of any information relating to dental claims. I understand that I am responsible for all costs of dental treatment, regardless of insurance coverage, on the day of service unless other arrangements have been made prior to the start of treatment. There will be a monthly finance charge of 1.5% (18%APR) for all unpaid balances over 60 days. By signing below, I acknowledge that I have read the Notice of Privacy Practices and have been given the opportunity to keep a copy of the notice.

Signature of Patient (Parent if Minor) _____