NEW YORK ORAL &
MAXILLOFACIAL SURGERY
DENTAL IMPLANT CENTER
MARK STEIN, DDS, MD
800A Fifth Avenue Suite 404 NEW YORK, NEW YORK 10065

Insurance Information

Date:_____

The following is for: ☐ the insured ☐ the person responsible for payment

Last Name:_____ First Name:_____ M.I._____

Gender: M F Family Status:_____ Birth Date:_____ SSN:_____

Phone (Home):_____ Phone (Work):_____ Ext: _____ Cell:_____

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

Employment Information

The following is for: ☐ the insured ☐ the person responsible for payment

Employer Name:_____ Occupation:_____

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

Phone:_____

Insurance Information

Dental Insurance Plan Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Dental Insurance:_____

Group Number:_____

Medical Insurance Plan Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Medical Insurance:_____

Group Number:_____

Note: General Anesthesia / I - V Sedation is an elective procedure which may not be covered by your Dental / Medical Insurance. Payment for this service is expected at the time of visit.

I hereby give my consent to Dr. Mark Stein and staff, to perform the indicated oral surgery on me / or my child _____ under local or general anesthesia.

_____ Date:_____

Signature of patient, parent or guardian

Responsibility Statement

I understand and acknowledge that I am financially responsible for the services provided for myself or for the above named, regardless of insurance coverage. I allow the use of my credit / debit card on file for all charges whether or not paid by my insurance company, within 60 days of any unpaid balance.

Account Number: _____ Expiration Date: _____

☐ VISA ☐ Mastercard ☐ Amex ☐ Discover _____

Signature

Authorization and Release

I have read and answered the questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to receive payment of benefits.

_____ Date: _____

Signature of patient, parent or guardian