RocklandRiversideDental
Jacob Wallach, DDS, PC
99 North Broadway Nyack, NY 10960

Name: (Last)_____(First)_____(MI)_____ ☐Male ☐Female

Address: _____ City _____ State _____ ZIP_____

SSN: _____DOB:_____Marital Status:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____E-mail Address: _____

Employer:_____

If full time student, name of college:_____

How do you prefer to be contacted for appointment:(Check all that apply) ☐Phone ☐E-mail ☐Text Message

If you are a new patient, who may we thank for referring you?_____

■ Insurance Information-Primary ■

Subscriber Name: _____Relationship to Patient: _____

Subscriber DOB: _____Subscriber SSN/ID: _____

Subscriber Employer: _____Insurance Company Name: _____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

■ Insurance Information-Secondary ■

Subscriber Name: _____Relationship to Patient: _____

Subscriber DOB: _____Subscriber SSN/ID: _____

Subscriber Employer: _____Insurance Company Name: _____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Jacob Wallach, DDS, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____**Relationship**: _____**Date**: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:_____