

KINGSTON DENTAL ASSOCIATES
370 KINGS MALL COURT
KINGSTON NY 12401
(845)-336-8478
FAX (845)-336-8607

Patient Information

Patient

Name _____
DOB _____, **Social Security #** _____
Are you a full time student? YES _____ NO _____
Name and Address of School _____

Primary Insurance

Insurance Subscriber Name _____
DOB _____, **Social Security#** _____
Home Address _____
Home Phone # _____, **Cell Phone** _____
Email Address _____

Subscriber Employer Name _____
Address _____ **Phone#** _____

Name of Insurance Carrier _____
Address _____ **Phone#** _____

Secondary Insurance

Insurance Subscriber Name _____
DOB _____, **Social Security#** _____
Home Address _____
Home Phone # _____, **Cell Phone** _____

Subscriber Employer Name _____
Address _____ **Phone#** _____

Name of Insurance Carrier _____
Address _____ **Phone#** _____

- I hereby certify that the above information provided is true and correct.
- I agree to be responsible for knowing my insurance coverage, including limitations, deductions, maximums and non-covered services.
- I agree to be financially responsible for any and all services provided that are not paid by my insurance company for any reason.
- I will inform this office if there is any change in my coverage, including termination or re-instatement of present coverage and/or addition of new coverage.

Signature of Patient or Responsible Party

Date