

Welcome to our practice



ROCKY POINT FAMILY DENTISTRY
809 RT 25A ROCKY POINT, NY 11778

In order to serve you efficiently please answer all answers accurately. All information is kept confidential.

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Social Security # _____ Date of birth _____

Home Number _____ Cell Number _____

Email Address _____

Sex: Male Female **Marital Status:** Single Married Child Other

Person responsible for payment _____

You will pay by: Cash Credit Check Insurance Care-Credit

We would like to thank who referred you: _____

Information of the Insured

It is fraud to give any incorrect information about your insurance. Please cooperate we are here to help you.

First Name _____ Last Name _____

Social Security# _____ Date of birth _____

Insurance Company _____

Relationship to you _____ Employer _____

Name of secondary insurance _____

Patient Signature _____ Date _____