SMILE SOLUTIONS

Robert P. Berg, DDS, PC
270 Nassau Boulevard
Garden City, NY 11530
516-872-8780

PATIENT INFORMATION

First Name:_____ **Last Name:**_____ **Middle:**_____

Address:_____

City, State, Zip:_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **E-mail:**_____

Birth date:_____ **Social Security:**_____

_____Male _____Female _____ Student _____ Single _____ Married _____Widowed

Do you have dental insurance? _____yes _____no Are you the insured? _____yes _____no
*****If no, provide all information for the insured(s):**

Primary Insurance Information: (You may also provide a copy of the insurance card.)

Employer:_____ **Insurance Carrier:**_____

Insurance ID#:_____ **Group #:**_____ **Provider Information Phone#:**_____

Claim Mailing Address:_____

Primary Insured's information:

Full Name:_____ **Social Security:**_____

Insured Birth Date:_____ **Insured's Relationship to Patient:**_____

Insured's Cell Phone:_____ **Insured's Work Phone:**_____

Secondary Insurance Information: (You may also provide a copy of the insurance card.)

Employer:_____ **Insurance Carrier:**_____

Insurance ID#:_____ **Group #:**_____ **Provider Information Phone#:**_____

Claim Mailing Address:_____

Secondary Insured's information:

Full Name:_____ **Social Security:**_____

Insured Birth Date:_____ **Insured's Relationship to Patient:**_____

Insured's Cell Phone:_____ **Insured's Work Phone:**_____