

Hudson Valley Dental Arts, P.C.
Dr. Lawrence Hamburg

Date: _____
Patient Name: _____ Date Of Birth: _____
Social Security #: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Bus. Phone: _____
Cell phone: _____
E-mail: _____ We would like you to receive of our
monthly newsletter, is this o.k.? _____ YES _____ NO

Family Physician: _____
Have there been any changes in your medical history? If so what? _____

Do you have insurance? _____ (if yes, which company) _____
Is the insurance listed under your name? _____
If not, Name: _____ Date Of Birth: _____
Social Security #: _____ Employer _____
Group #: _____

Referred by: _____

Person(s) responsible for this account: _____

How do you intend to pay for this visit: Cash __ Check __ Credit Card __

**Our mission is to deliver the finest treatment possible today,
performed to your satisfaction. Payment is due at the time of
treatment. If this is not convenient for you, please discuss
payment options with our office coordinator *before* treatment.**

**Should I default, I agree to pay 2% monthly service charges,
legal fees, and/or 29% collection fees.**

Signature: _____