Cornerstone Dental of Green Brook
314 US HWY 22 WEST
SUITE D
GREEN BROOK, NJ 08812
732-424-8483

REGISTRATION
HISTORY
DATE______________

PATIENT'S NAME____

NAME OF SPOUSE____

IF A CHILD, PARENT'S NAME____

STREET ADDRESS____

CITY______________________________ STATE____________________ ZIP______

CELLPHONE#_______________________ HOME#_____________________________________

E-MAIL ADDRESS____

PATIENT EMPLOYED BY ______________________________PHONE__________________________

BUSINESS ADDRESS____

PRESENT POSITION____HOW LONG ________________

SPOUSE EMPLOYED BY_______________________________PHONE___________________________

BUSINESS ADDRESS____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED______________PHONE_________________

WHO WILL PAY THIS ACCOUNT____

SOCIAL SECURITY NUMBER____

SPOUSE'S SOCIAL SECURTY NUMBER____
DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES
YES________ NO_________

IF SO, NAME OF COMPANY______________________________POLICY#___________________
IF INSURANCE COVERED, SOCIAL SECURITY # OF PERSON COVERED_____________

DATE OF BIRTH OF THE PERSON COVERED_____________

IF YOUR INSURANCE DOES NOT PAY THE BILL, WHO IS RESPONSIBLE FOR PAYING IT________

WHOM MAY WE THANK FOR REFERRING YOU____

PURPOSE OF THIS APPOINTMENT____

PLEASE COMPLETE REVERSE SIDE

Authorization to Release Information

I hereby authorize the above named dentist(s) to provide any insurance company claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

______________________________ ___________________________
Patient or Authorized Guardian's Signature Date

PHOTO & VIDEO RELEASE

I recognize that my dentist and team are proud of the quality treatment that they will provide to me. I, hereby, provide my consent for medical photographs, videos or audio to be taken of me and/or the procedure being done by my dentist and the dental team. I understand that the information may be used for the following purposes:

- **dental records and research**
- **purposes of dental education including lectures, seminars, demonstrations, professional publications such as journals or textbooks**
- **dental office marketing materials and advertisements including websites, social media platforms and printed materials and patient education**

By consenting to release my dental photographs and/or audio/video, I understand that I will not receive payment from any party. Although these photographs, videos or audio will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to photographs or videos will in no way affect the dental care that I will receive.

I authorize the use of these images:

- **For demonstration purposes including an office photo album**
- **For our website, professional journal and/or advertisement purposes or social media accounts (examples: Facebook, Instagram, Twitter, etc...)**
- **I give my consent for ONLY non-identifying photos taken**

By signing below, I confirm that I understand this consent and release form completely and that any questions I had have been asked and answered.

Patient Name:____________________ Signature: ____________________________

Date: ____________________________