Rob S. Steiner, DMD
Diplomate, American Board of Oral Maxillofacial Surgery

Sean Lindsey, DDS
Oral Maxillofacial Surgeon
Dental Anesthesiologist

Steiner Rotenberg & Lindsey
oral surgery | periodontics

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Diplomate, American Board of Periodontology

WELCOME TO OUR OFFICE

NAME: _____ BIRTH DATE: _____ AGE: _____

SOCIAL SECURITY NUMBER: _____ GENDER: _____

ADDRESS: _____ E-MAIL: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ STUDENT Y/N: _____ WHERE?_____

PERSON FINANCIALLY RESPONSIBLE: _____ DAY PHONE: _____

RELATIONSHIP TO PATIENT: _____ SAME ADDRESS Y/N:_____

IF NO, WHICH ADDRESS: _____

REFERRED BY: _____

PRIMARY INSURANCE

POLICY HOLDER: _____

SSN: _____

DATE OF BIRTH: _____

EMPLOYER: _____

MEDICAL INS: _____

INS ID# _____ GROUP # _____

DENTAL INS: _____

INS ID# _____ GROUP # _____

SECONDARY INSURANCE

POLICY HOLDER: _____

SSN: _____

DATE OF BIRTH: _____

EMPLOYER: _____

MEDICAL INS: _____

INS ID# _____ GROUP # _____

DENTAL INS: _____

INS ID# _____ GROUP # _____

We will be happy to submit your insurance for you; however, the financial obligation for the treatment we render to you is your responsibility. I understand that I am financially responsible for all charges whether or not it is paid for by my insurance company. I authorize Steiner, Rotenberg, & Lindsey LLC to release all information necessary to process my insurance claims. I authorize my insurance carrier to make payment to Steiner, Rotenberg, & Lindsey LLC

Signature of Patient/Parent or Guardian: _____ Date: _____