Richard Lipshultz DMD
Michelle Lipshultz DMD
586 Knickerbocker Rd.
Cresskill, NJ 07626

If you have Dental Insurance, please print out and complete this form for your appointment.

Patient Name: _____

Dental Insurance Company: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Group Number: _____

Subscriber ID Number: _____

Subscriber's Relationship to Patient: _____

Is patient covered by additional dental Insurance? Yes No

Additional Dental Insurance Company: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Subscriber ID Number: _____

Group Number: _____

Subscriber's Relationship to Patient: _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s) have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Dr.Richard Lipshultz or Dr. Michelle Lipshultz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

The above-named dentists may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services.

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

Printed Name of Patient,Parent or Guardain_____

Relationship to Patient:_____