Steven M. Haber, D.D.S.
Diplomate, American Board of Oral and Maxillofacial Surgery
N.J Specialty Permit No.2791

1319C Anderson Avenue
Fort Lee, New Jersey, 07024
Tel:(201) 224-0094 Fax:(201) 224-0095

Patient Name:_____

Insured's Name:_____

Insured's Soc.Sec.#_____ Insured's Date of Birth:_____

Insured's Employer Name and Address:_____

Dental Insurance:_____

Policy/ID#:_____ Group#:_____

Medical Insurance:_____

Policy/ID#:_____ Group#:_____

Ultimately, you are financially responsible for the cost of this care, even if we participate in your insurance plan. Any services that are not covered by your insurance are your responsibility. If we do not participate in your insurance plan, you will pay the doctor and your insurance company will reimburse you to the extent of your coverage.

I understand and agree to the above terms.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date