

David L. Sykes, DMD, LLC  
Oral & Maxillofacial Surgery

David L. Sykes, D.M.D.  
NJ Specialty License # 2948

Benaifer Preziosi, D.M.D.  
Specialty License #5793

# Welcome To Our Practice

Date: \_\_\_\_\_

Patient: (Mr., Mrs., Ms., Dr.) First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Gender:  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
Driver's Lic. #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: (\_\_\_\_\_) \_\_\_\_\_  
Dentist: \_\_\_\_\_ Medical Doctor: \_\_\_\_\_  
Have you ever been a patient in our practice?  Yes  No  
Method of Personal Payment:  Cash  Check  Credit Card  Care Credit

Who referred you to our office?  Dentist  Ortho.  Physician  Hospital  
 Friend  TV  Yellow Pages  Self

In case of emergency notify:

Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_

Primary: Who will be responsible for your account?  Self  Spouse  Father  
 Mother  Other: \_\_\_\_\_ (if self, skip to next box)  
Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Home Tel. (\_\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Tel. (609) \_\_\_\_\_

Secondary: Who carries the secondary insurance?  Spouse  Father  
 Mother  Other: \_\_\_\_\_  
Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Home Tel. (\_\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Tel. (609) \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO ORAL SURGEON:** I hereby authorize the undersigned office to release any information in the course of my examination or treatment. I also authorize payment directly to the oral surgeon of the surgical and/or dental benefits and major medical benefits, if any, otherwise payable to me for his services as described above. I understand that I am financially responsible for changes not covered by this authorization.

Signed: \_\_\_\_\_

PRIMARY DENTAL INSURANCE COMPANY	
Employer	_____
Bus. Address	_____
Bus. Tel. #:	_____ Plan _____
Ins. Co. Name	_____
Address	_____
	_____ Phone: ( _____ ) _____
Group #:	_____ Group Name: _____
Insured Party	_____ Relation _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____
Street:	_____
City, State, Zip:	_____
Phone:	_____ S.S. # _____
I.D. #:	_____

PRIMARY MEDICAL INSURANCE COMPANY	
Employer	_____
Bus. Address	_____
Bus. Tel. #:	_____ Plan _____
Ins. Co. Name	_____
Address	_____
	_____ Phone: ( _____ ) _____
Group #:	_____ Group Name: _____
Insured Party	_____ Relation _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____
Street:	_____
City, State, Zip:	_____
Phone:	_____ S.S. # _____
I.D. #:	_____

SECONDARY DENTAL INSURANCE COMPANY	
Employer	_____
Bus. Address	_____
Bus. Tel. #:	_____ Plan _____
Ins. Co. Name	_____
Address	_____
	_____ Phone: ( _____ ) _____
Group #:	_____ Group Name: _____
Insured Party	_____ Relation _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____
Street:	_____
City, State, Zip:	_____
Phone:	_____ S.S. # _____
I.D. #:	_____

SECONDARY MEDICAL INSURANCE COMPANY	
Employer	_____
Bus. Address	_____
Bus. Tel. #:	_____ Plan _____
Ins. Co. Name	_____
Address	_____
	_____ Phone: ( _____ ) _____
Group #:	_____ Group Name: _____
Insured Party	_____ Relation _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____
Street:	_____
City, State, Zip:	_____
Phone:	_____ S.S. # _____
I.D. #:	_____

**CERTIFICATION OF NON-MILITARY SERVICE**

I hereby certify that I am neither in the military reserves nor am I in the active military service at this time, nor do I expect to be in the future.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**IMPORTANT INFORMATION ABOUT YOUR RIGHT TO PRIVACY**

A copy of David L. Sykes, DMD, L.L.C. Notice of Privacy Practices is posted and has been made available to me. I understand that I have the right to review the notice, which is available in the office of David L. Sykes, DMD prior to signing this consent. David L. Sykes, DMD, L.L.C. reserves the right to make changes to the Notice of Privacy Practices. Revised copies are available at the front reception area.

I ACKNOWLEDGE THAT I HAVE BEEN AFFORDED THE OPPORTUNITY TO CONSIDER DAVID L. SYKES, DMD, L.L.C. NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING OF THIS CONSENT AND MAKING HEALTHCARE DECISIONS.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Patient/Guardian refuses to sign statement

\_\_\_\_\_  
Witness