Greenbrook DENTISTRY S.C.

# Patient Information Form

Date ______________ Account # ______________

## PATIENT (or, Person Responsible for Account)

Primary Dentist: MOR WAL KAR HOV BEN RIF RLH MPW

First Name: ______________________ MI: ____

Last Name: ______________________________

*Please Circle Preference: Mr. Mrs. Ms. Dr. Atty.* _____

## ADDRESS and PHONE

Street: ______________________________

City: ______________________ State: ______

Zip: __________ Email: ______________________

Home Phone: (_____) ______________

Work Phone: (_____) ______________

Social Security Number: ______ – ______ – ______

Date of Birth: ______________________________

## EMPLOYMENT

Employer: ______________________________

Street: ______________________________

City: ______________________ State: ______

Zip: __________

## DEPENDENT CHILDREN ON THIS ACCOUNT

Primary Dentist: MOR HOV RIF RLH

______________________ Date of Birth: __________

______________________ Date of Birth: __________

______________________ Date of Birth: __________

______________________ Date of Birth: __________

______________________ Date of Birth: __________

## DENTAL INSURANCE

Name of Insurance: ______________________

Group No.: __________ Policy No.: __________

Policyholder ______________________
*(if different than above)*

Street: ______________________________

City: ______________________ State: ______

Zip: __________ Phone: (_____) ______________

Family members covered under this policy: __________

______________________________

Whom may we thank for referring you?

Name: ______________________________

Address: ______________________________

## SPOUSE

Primary Dentist: MOR WAL KAR HOV BEN RIF RLH MPW

First Name: ______________________ MI: ____

Last Name: ______________________________

*Please Circle Preference: Mr. Mrs. Ms. Dr. Atty.* _____

## ADDRESS and PHONE

Street: ______________________________

City: ______________________ State: ______

Zip: __________ Email: ______________________

Home Phone: (_____) ______________

Work Phone: (_____) ______________

Social Security Number: ______ – ______ – ______

Date of Birth: ______________________________

## EMPLOYMENT

Employer: ______________________________

Street: ______________________________

City: ______________________ ______

Zip: __________

## DENTAL INSURANCE

Name of Insurance:

Group No.: __________ Policy No.: __________

Policyholder ______________________
*(if different than above)*

Street: ______________________________

City: ______________________

Zip: __________ Phone: (_____) ______________

Family members covered under this policy: __________

______________________________

## RELEASE OF INFORMATION
## ASSIGNMENT OF BENEFITS

I authorize release of all information required to process dental insurance claims and permit a copy of this authorization to be used in place of the original assignment.

I assign Greenbrook Dentistry, SC any benefits I am entitled from my insurance company for services provided and understand I am financially responsible for all charges regardless of type or level of insurance coverage.

______________________________ __________
*Signature (Patient or Parent/Guardian)* *Date*

## A Note to Our Patients

Our practice strives to be in compliance with the HIPAA laws, and we have a lengthy “Notice of Privacy Practices” available for you to read or obtain a copy of when you come to the office. The Federal Government requires lots of fine print, but we can sum it up very simply: **We have never, and will never, share or release any information about you to anyone else without your permission, unless required by law.** Period.

We do ask patients for written permission to send information to insurance carriers specifically related to pre-estimates of dental benefits, or for claims following treatment. You will be asked to sign an acknowledgment that you are aware of the privacy policy, and that you authorize and consent the use, disclosure and release of information to carry out treatment, pre-determine benefits, and submit claims for payment to insurance carriers or other parties you may designate.

If you have any questions, please ask us when you are in the office.