

Patient Information

1 PATIENT INFORMATION

First Name _____
Last Name _____
M.I. _____ Preferred Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Who/what referred you to our office? _____
Sex: Male Female
Marital Status: Divorced Married
 Separated Single Widowed
Birthdate (MM/DD/YYYY) _____
Social Sec.: _____
Email: _____

Would you like to receive a text message from us to remind you of your appointment? Yes No

Check all that apply. This person is the:
 Patient Policy Holder Responsible Party

2 INSURANCE INFORMATION

Name of Policy Holder _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Home _____
Cell Phone _____
Sex: Male Female
Marital Status: Divorced Married
 Separated Single Widowed
Birthdate (MM/DD/YYYY) _____
Social Sec.: _____
Relationship to Patient _____
Name of Employer _____
Primary Insurance
Insurance Co. Name _____
Group Number _____
Secondary Insurance
Insurance Co. Name _____
Group Number _____

3 RESPONSIBLE PARTY

Name _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Home _____
Cell Phone _____ Sex: Male Female
Marital Status: Divorced Married
 Separated Single Widowed Birthdate (MM/DD/YYYY) _____
Social Sec.: _____

4 AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I authorize the professional office of my dentist, (**Dr. Saqib H. Mohajir - Pinewood Dental, PC**) to release all necessary health information identifying me to the following recipients only:

- 1.) My primary care physician, and/or medical/dental specialists, to aid in the diagnosis or treatment of my medical or dental health.
- 2.) My insurance company, to allow for payment of any claims made by this office toward my dental care. I assign all insurance benefits, otherwise payable to me, to the treating doctor for services rendered. I authorize the use of the signature below on all insurance submissions.

I HAVE READ AND UNDERSTAND THE ABOVE FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Dated _____ Patient signature _____

If you are signing as a representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____