PINEWOOD DENTAL
11979 W. 143RD ST., ORLAND PARK, IL 60467
(708) 364-0641

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 RECIEPT 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______________________

Source of Authority (Parent/Guardian)______________________________