GREENWAY
FAMILY DENTAL

Patient Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Preferred Name: _____ SS#: _____ Birth Date: _____

Title: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Address: _____
Street Address *Apartment/Unit #*

_____
City ***State*** ***ZIP Code***

Phone: _____ Email _____

Cell: _____ Best time to call: _____

Employer: _____ Employer Phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____

Whom may we thank for referring you to our practice: _____

Financial Responsibility

This only needs to be filled out if the insurance subscriber is other than patient, or if under the age of 18.
The following is for: ☐ The patient's spouse ☐ The person responsible for payment ☐ Both ☐ Neither not-applicable

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Last *First* *M.I.*

Preferred Name: _____ SS# _____ Birth Date: _____

Title: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Address: _____
Street Address *Apartment/Unit #*

_____
City ***State*** ***ZIP Code***

Phone: _____ Email _____

Cell: _____ Best time to call: _____

Employer: _____ Employer Phone: _____

Insurance Information

Primary Dental Insurance

Subscriber's Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber ID: _____ Subscriber's Birth Date: _____ Group#: _____

Insurance Company's Name: _____

Insurance Company Address: _____

Street Address *Apartment/Unit #*

_____

City ***State*** ***ZIP Code***

Insurance Company's Phone Number: _____

Secondary Dental Insurance

Subscriber's Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber ID: _____ Subscriber's Birth Date: _____ Group#: _____

Insurance Company's Name: _____

Insurance Company Address: _____

Street Address *Apartment/Unit #*

_____

City ***State*** ***ZIP Code***

Insurance Company's Phone Number: _____

Insurance Authorization:

I authorize my insurance company to pay Greenway Family Dental all insurance benefits rendered. I authorize Greenway Family Dental to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance company.

Print Name: _____

Sign Name _____

Date: _____