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drggg.com

TODAY'S DATE _____

PATIENT NAME _____ SEX: M F BIRTHDATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
SS# _____ PHONE# _____ CELL# _____ WORK# _____ EXT _____
EMAIL ADDRESS: _____

SINGLE MARRIED WIDOWED SEPARATED DIVORCED

OCCUPATION _____ EMPLOYER _____
EMPLOYER ADDRESS _____ EMPLOYER PHONE # _____

SPOUSE'S NAME _____ BIRTHDATE _____ SOCIAL SECURITY# _____
OCCUPATION _____ EMPLOYER _____
SPOUSES EMPLOYER PHONE # _____ SPOUSE'S CELL# _____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)

NAME _____ RELATIONSHIP _____
HOME PHONE# _____ WORK PHONE# _____ CELLPHONE# _____

HOW WERE YOU REFERRED TO OUR OFFICE? (phonebook, friend, insurance company, Newspaper ad etc.) _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT _____

PRIMARY DENTAL INSURANCE:

DENTAL INSURANCE CO. _____
SUBSCRIBER ID # _____ KODAK 6 DIGIT ID # _____ GROUP # _____
SUBSCRIBER'S NAME _____ BIRTHDATE _____ SS# _____
SUBSCRIBER'S EMPLOYER _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE Y N

RELATIONSHIP TO PATIENT _____

SECONDARY DENTAL INSURANCE:

DENTAL INSURANCE CO. _____
SUBSCRIBER ID # _____ KODAK 6 DIGIT ID # _____ GROUP # _____
SUBSCRIBER'S NAME _____ BIRTHDATE _____ SS# _____
SUBSCRIBER'S EMPLOYER _____

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. GROSKIN ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHEATHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DR. GROSKIN TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

RESPONSIBLE PARTY SIGNATURE _____

RELATIONSHIP _____ DATE: _____