

Brian S. Gurinsky, DDS, MS

Diplomate, American Board of Periodontology

www.briangurinsky.com

NAME OF PATIENT \_\_\_\_\_  
LAST FIRST MI

PREFERRED NAME \_\_\_\_\_ SS# \_\_\_\_\_

MALE  FEMALE  SINGLE  MARRIED  CHILD  DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_ EXT \_\_\_\_ (Cell) \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET Apt # CITY STATE ZIP

E-MAIL ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?**

NAME \_\_\_\_\_ DENTAL OFFICE  RELATIVE  FRIEND  OTHER

**PERSON TO CONTACT IN CASE OF EMERGENCY**

RELATIVE \_\_\_\_\_ PHONE \_\_\_\_\_

FRIEND \_\_\_\_\_ PHONE \_\_\_\_\_

**RESPONSIBLE PARTY, IF OTHER THAN PATIENT**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (w) \_\_\_\_\_

SS # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

RELATIONSHIP TO PATIENT: SPOUSE  PARENT  OTHER

EMPLOYER \_\_\_\_\_  
COMPANY NAME ADDRESS

**SEE OVER FOR INSURANCE INFORMATION** ▼

## INSURANCE INFORMATION

Dental INSURANCE COMPANY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
CITY STATE ZIP

PHONE: (\_\_\_\_\_) \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_  
LAST NAME FIRST NAME

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

EMPLOYER \_\_\_\_\_

GROUP # \_\_\_\_\_ ID # \_\_\_\_\_

I hereby authorize the office of Brian S. Gurinsky, DDS, MS to affix my name to any and all claims or documents related to me . To the extent permitted under applicable law, I authorize release of any information relating to this claim. This "signature on file" will be valid for this date forward and can be terminated by me in writing at any time.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### **Please choose one of the following options:**

- I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Dr. Brian S. Gurinsky. I will be paying my estimated co-pay at the time of treatment and my credit card number will be kept on file . I hereby authorize this office to keep my signature on file and to charge my credit card account for any and all treatment fees remaining after my insurance carrier has processed my claim, or any balance still remaining after 60 days.

Cardholder's Name \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_

Credit card number \_\_\_\_\_

Expiration date \_\_\_\_\_

- I will be paying the full amount of my appointment at the time of service by one of the following: CASH, CHECK, CREDIT/DEBIT CARD or 3<sup>rd</sup> PARTY FINANCING. This office will file my insurance claim on my behalf and will request that the benefits be reimbursed to me

Signed \_\_\_\_\_

Date \_\_\_\_\_