GriecoDentistry™
healthy smiles. naturally.

PATIENT INFORMATION

(CONFIDENTIAL)-PLEASE PRINT

PURPLE

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL _____ SOC. SEC. # _____ BIRTHDAY _____

I PREFER TO BE CONTACTED AT MY ☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ OTHER _____

IF COLLEGE STUDENT: NAME OF SCHOOL _____ CITY _____ STATE _____

ARE YOU CURRENTLY A FULL-TIME OR PART-TIME STUDENT? (CIRCLE ONE)

PATIENT'S OR PARENT'S EMPLOYER _____ PROFESSION _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S OR PARENT'S NAME _____ EMPLOYER _____

WHOM MAY WE THINK FOR REFERRING YOU? _____

IN CASE OF AN EMERGENCY PLEASE CONTACT: _____ PHONE: _____

RELATIONSHIP TO THIS PERSON _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

(IF DIFFERENT FROM ABOVE) ADDRESS _____

HOME PHONE _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

NOTE TO PATIENTS WITH DENTAL INSURANCE

DR. GRIECO DOES NOT PARTICIPATE WITH ANY INSURANCE COMPANIES AND IS CONSIDERED TO BE OUT OF NETWORK DENTIST BY YOUR DENTAL PLAN. IN MOST CASES, YOU WILL STILL BE ABLE TO RECEIVE BENEFITS FROM YOUR DENTAL INSURANCE. IF YOU ARE CONCERNED ABOUT WHAT WILL AND WILL NOT BE COVERED, IS YOUR RESPONSIBILITY TO CONTACT THE COMPANY. WE REQUIRE THAT YOU EITHER PAY YOUR BILL, INFO, AT THE TIME OF SERVICE OR MAKE FINANCIAL ARRANGEMENTS WITH THE FINANCIAL ADVISOR BEFOREHAND. WE OFFER PAYMENT OPTIONS FOR ANY TREATMENT OVER $350. OUR OFFICE WILL FILL OUT ALL THE NECESSARY PAPERWORK FOR YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO SUBMIT THE PAPERWORK NEEDED TO RECEIVE YOUR BENEFITS. INSURANCE COMPANY WILL THEN SEND THE REIMBURSEMENT CHECK DIRECTLY TO YOU.

ATTENTION PATIENTS UNDER MEDICAL ASSISTANCE OR WITH MEDICARE, MEDICAID, OR SECURITY BLUE.
DR. GRIECO IS NOT A PROVIDER WITH ANY OF THESE PROGRAMS. THEREFORE, YOU WILL NOT RECEIVE ANY BENEFITS FROM THE DENTAL PLAN, PROVIDED THROUGH THESE PROGRAMS, SHOULD YOU HAVE TREATMENT DONE AT OUR OFFICE. IF YOU WISH TO BECOME A PATIENT WITH DR. GRIECO WE WILL BE VERY HAPPY TO HAVE YOU, BUT PLEASE KEEP IN MIND THAT YOU WILL BE RESPONSIBLE TO PAY YOUR BILLS IN FULL AND AT THE TIME OF SERVICE.

NOTE TO PATIENTS WITH DENTAL INSURANCE I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWER. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____

SIGNATURE OF PATIENT OR PARENT IF MINOR

REGISTRATION