

HOLBROOK PROFESSIONAL CENTER  
900 MAIN STREET, SUITE 104  
HOLBROOK, NEW YORK 11741

TELEPHONE 981-5600

RICHARD H. CHANIN, D.D.S.  
GREG B. CINSKI, D.M.D.



COSMETIC & FAMILY DENTISTRY  
www.holbrooksmiles.com

PATIENT REGISTRATION

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Email \_\_\_\_\_

Sex: Male  Female  Martial Status: Single  Married  Separated  Divorced  Widowed

How did you hear about our practice? \_\_\_\_\_

-----  
**TO GET TO KNOW YOU BETTER PLEASE LIST ANY HOBBIES, INTERESTS, OR SPORTS**

\_\_\_\_\_  
\_\_\_\_\_

If a child or student give school name and grade level \_\_\_\_\_

Purpose of visit \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Present position \_\_\_\_\_ How long held? \_\_\_\_\_

-----  
Who will be responsible for this account? Self ( ) Spouse ( ) Parent ( )  
(If you checked "Self" please skip this section and continue with insurance information)

Person responsible for this account, other than above patient:

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_

HOLBROOK PROFESSIONAL CENTER  
900 MAIN STREET, SUITE 104  
HOLBROOK, NEW YORK 11741

TELEPHONE 981-5600

RICHARD H. CHANIN, D.D.S.  
GREG B. CINSKI, D.M.D.

COSMETIC & FAMILY DENTISTRY  
www.holbrooksmiles.com



For Patients covered by Dental Insurance:

Subscriber's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Insurance Company \_\_\_\_\_

Relationship to Patient ( ) Self ( ) Spouse ( ) Parent or Guardian

Is the patient covered by another dental insurance?

If yes, please fill out the next section.

-----  
Secondary Dental Insurance

Subscriber's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Insurance Company \_\_\_\_\_

Relationship to Patient ( ) Self ( ) Spouse ( ) Parent or Guardian

To better acquaint ourselves with your family please list other family members - Thank You

| Name  | Age   |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

APPOINTMENTS: This time is reserved exclusively for you. **24 hours** notice is appreciated if you are unable to keep your appointment. A minimum charge will be made for a broken or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of office overhead which still has to be paid whether you are present or not. In addition, other patients cannot be scheduled because WE HAVE RESERVED THE TIME FOR YOU!

HOLBROOK PROFESSIONAL CENTER  
900 MAIN STREET, SUITE 104  
HOLBROOK, NEW YORK 11741

TELEPHONE 981-5600

RICHARD H. CHANIN, D.D.S.  
GREG B. CINSKI, D.M.D.

COSMETIC & FAMILY DENTISTRY  
www.holbrooksmiles.com



**MEDICAL AND DENTAL HISTORY**

TODAY'S DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ARE YOU HAVNG PAIN AND DISCOMFORT AT THIS TIME?

Circle  
Yes            No

HAVE YOU EVER HAD A BAD DENTAL EXPERIENCE?

Yes            No

WHEN WAS YOUR LAST DENTAL EXAM?

\_\_\_\_\_

WHEN & WHERE WERE YOUR LAST DENTAL X-RAYS?

\_\_\_\_\_

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING?

INDICATE WITH A ( ✓ )

- |   |  |
|---|--|
| <input type="checkbox"/> Gums That Bleed  | <input type="checkbox"/> Gums That Are Red, Swollen or Tender            |
| <input type="checkbox"/> Gums That Have Pulled Away From Your Teeth                 | <input type="checkbox"/> Teeth That Are Loose                            |
| <input type="checkbox"/> Bad Breath   | <input type="checkbox"/> Change in the Way Your Teeth Fit Together       |
| <input type="checkbox"/> Teeth That Are Sensitive to Cold, Heat, Sweets or Pressure | <input type="checkbox"/> Food Impaction                                  |
| <input type="checkbox"/> Clenching or Grinding                                      | <input type="checkbox"/> Burning of Tongue                               |
| <input type="checkbox"/> Swelling or Lumps in Mouth                                 | <input type="checkbox"/> Frequent Blisters on Lips or Mouth (cold sores) |
| <input type="checkbox"/> Pain Around the Ear  | <input type="checkbox"/> Unusual Sounds in Ear When Eating               |
| <input type="checkbox"/> Unpleasant Taste   | <input type="checkbox"/> Complications from Extractions                  |
| <input type="checkbox"/> Periodontal Treatment                                      | <input type="checkbox"/> Orthodontic Treatment                           |
| <input type="checkbox"/> Mouth Breathing  | <input type="checkbox"/> Oral Habits (i.e. fingernail biting, etc.)      |
| <input type="checkbox"/> Cigarettes, Pipe or Cigar Smoking                          | <input type="checkbox"/> Frequency of Brushing _____ Times per day       |
| <input type="checkbox"/> Dental Floss   | <input type="checkbox"/> Inter Dental Stimulators                        |
| <input type="checkbox"/> Anti-plaque Rinses   | <input type="checkbox"/> Fluoride Supplements                            |

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATION NOW? \_\_\_\_\_

HAVE YOU BEEN A PATIENT IN THE HOSPITAL IN THE LAST TWO YEARS? \_\_\_\_\_

HAVE YOU HAD ANY MAJOR OPERATION? \_\_\_\_\_ IF SO, WHAT? \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

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



# HEALTH HISTORY

Patient's Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Place a mark on "YES" or "NO" to indicate if you have had any of the following:  
**HAVE YOUR BEEN ADVISED BY YOUR PHYSICIAN THAT YOU NEED TO BE PRE-MEDICATED FOR DENTAL TREATMENT?** YES  NO

|  |  |                                     |  |   |  |
|--|--|-------------------------------------|--|---|--|
| Anemia   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Eye Disease                         | <input type="checkbox"/> YES <input type="checkbox"/> NO | Respiratory Disease   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Arthritis, Rheumatism                            | <input type="checkbox"/> YES <input type="checkbox"/> NO | Fainting or Dizziness               | <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatic Fever   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Heart Valve                           | <input type="checkbox"/> YES <input type="checkbox"/> NO | Frequent Ear Infections             | <input type="checkbox"/> YES <input type="checkbox"/> NO | Scarlet Fever   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Headaches                           | <input type="checkbox"/> YES <input type="checkbox"/> NO | Shortness of Breath   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Murmur                        | <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinus Trouble   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Blood Disease                                    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Problems                      | <input type="checkbox"/> YES <input type="checkbox"/> NO | Stents  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Blood Thinners                                   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis Type _____                | <input type="checkbox"/> YES <input type="checkbox"/> NO | Stroke  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Blood Transfusion                                | <input type="checkbox"/> YES <input type="checkbox"/> NO | Herpes                              | <input type="checkbox"/> YES <input type="checkbox"/> NO | Swollen Neck Glands   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer   | <input type="checkbox"/> YES <input type="checkbox"/> NO | High Blood Pressure                 | <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid Problems  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chemical Dependency                              | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIV Positive/AIDS                   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis/TB   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chemotherapy                                     | <input type="checkbox"/> YES <input type="checkbox"/> NO | Jaundice                            | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tumor or Growths  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Circulatory Problems                             | <input type="checkbox"/> YES <input type="checkbox"/> NO | Jaw Pain                            | <input type="checkbox"/> YES <input type="checkbox"/> NO | Ulcer or Colitis  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congenital Heart Lesions                         | <input type="checkbox"/> YES <input type="checkbox"/> NO | Joint Replacement (Knee, Hip, etc.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | Venereal Disease  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cortisone Treatments                             | <input type="checkbox"/> YES <input type="checkbox"/> NO | Kidney Disease                      | <input type="checkbox"/> YES <input type="checkbox"/> NO | Women:<br>Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>Due Date _____<br>Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>Are you taking birth control pills? <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| Cough, Persistent or Bloody                      | <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Disease                       | <input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| Depression                                       | <input type="checkbox"/> YES <input type="checkbox"/> NO | Low Blood Pressure                  | <input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| Diabetes   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Mitral Valve Prolapse               | <input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| Emotional Problems                               | <input type="checkbox"/> YES <input type="checkbox"/> NO | Nervousness                         | <input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| Emphysema  | <input type="checkbox"/> YES <input type="checkbox"/> NO | Pacemaker                           | <input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| Epilepsy/Seizures                                | <input type="checkbox"/> YES <input type="checkbox"/> NO | Radiation Treatment                 | <input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |

**MEDICATIONS**

Have you ever taken any of the following Bisphosphonates? \_\_\_\_\_  
 Fosamax \_\_\_\_\_ Boniva \_\_\_\_\_ Actonel \_\_\_\_\_ Other \_\_\_\_\_

**Describe any current medical condition or treatment, even though not listed above.**

**ALLERGIES**

- Aspirin
- Codeine
- Latex
- Local Anesthesia (Novocaine)
- Penicillin
- Sulfur
- Other \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true & correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date \_\_\_\_\_ Signature of patient \_\_\_\_\_

| CURRENT MEDICATION | REASON | RE-CERTIFICATION: I certify that the answers given are correct to the best of my knowledge. |        |           |
|--------------------|--------|---|--------|-----------|
|                    |        | DATE  | CHANGE | SIGNATURE |
|                    |        |   |        |           |
|                    |        |   |        |           |
|                    |        |   |        |           |
|                    |        |   |        |           |

Richard Chanin, DDS & Greg Cinski, DMD  
900 Main Street  
Holbrook, NY 11741

### Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

#### Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **January 1, 2011**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

**Your Authorization:** In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

---

#### Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

**Treatment:** We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**To You Or Your Personal Representative:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Public Health and Public Benefit:** We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at

risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

**Decedents:** We may disclose health information about a decedent as authorized or required by law.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

---

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you **\$0.10** for each page, **\$25.00** per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**Electronic Notice:** You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

## Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Christina Monelt**

Telephone: **631-981-5600** Fax: **631-981-5637**

E-mail: **holbrooksmiles@gmail.com**

Address: **900 Main Street, Holbrook, NY 11741**

**RICHARD H. CHANIN, D.D.S.**  
**&**  
**GREG B. CINKSI, D.M.D.**  
**900 MAIN STREET**  
**HOLBROOK, NEW YORK 11741**  
**(631) 981-5600**

Acknowledge of Receipt of Notice of Privacy Practices  
And Consent for Disclosure for Treatment, Payment and Operations

**ACKNOWLEDGEMENT AND CONSENT**

**SECTION A: PATIENT GIVING ACKNOWLEDGEMENT AND CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

---

**SECTION B: TO THE PATIENT:**

**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read this Notice carefully before signing this Acknowledgement and Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we

received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

**NAME: (Patient, Parent or Guardian)**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Acknowledgement and Consent form and your Notice of Privacy Practices. I understand that, by signing this Acknowledgement and Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorization to Release Health Care Information to Your Family and Friends:**

I authorize you to use, release or disclose my healthcare information for treatment, payment or for healthcare operations to the following family members and friends. This authorization will remain in effect unless revoked by me in writing.

| Name  | Relationship to Patient |
|-------|-------------------------|
| _____ | _____                   |
| _____ | _____                   |
| _____ | _____                   |
| _____ | _____                   |

Signature of Patient, Parent or Guardian:

\_\_\_\_\_ **Date:** \_\_\_\_\_



HOLBROOK PROFESSIONAL CENTER  
900 MAIN STREET • SUITE 104  
HOLBROOK, NEW YORK 11741

TELEPHONE 981-5600

SIGNATURE RELEASE STATEMENT

1. PROCESS ALL INSURANCE CLAIMS,
2. TO ENSURE PAYMENT FOR SERVICES RENDERED,
3. TO RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES, AND
4. TO RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY, FOR YOUR TREATMENT.

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Chanin. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Please Print

Patient \_\_\_\_\_ Responsible Party \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_