Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

First Name_____ **Last Name** _____**Preferred Name**_____

Address_____ **City**_____ **State**_____ **Zipcode**_____

Home Phone_____ **Work Phone**_____ **Ext**_____ **Cell**_____

Birthdate_____**SS#**_____ **Drivers License#**_____

Email_____ ☐ **I would like to receive correspondences via email**

Check Appropriate Box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

If Full Time Student, Name of School/College_____ **City**_____ **State**_____

Patient or Parent's Employer_____**Work Phone**_____

Business Address_____ **City**_____ **State**_____**Zip**_____

Spouse or Parent's Name_____**Employer**_____**Work Phone**_____

Person to Contact in Case of Emergency_____ **Phone**_____

Whom May We Thank For Referring You?_____

Responsible Party

Relationship

Name of Person Responsible for this Account_____**to Patient**_____

Address_____**Home Phone**_____

Email_____**Cell Phone**_____

Driver's License#_____ **Birthdate**_____

Employer_____**Work Phone**_____**SS#**_____

For your convenience, we offer the following methods of payment. CO-PAYMENT DUE AT TIME OF SERVICE.

☐ **Cash** ☐ **Personal Check** ☐ **VISA** ☐ **MasterCard** ☐ **American Express** ☐ **Discover** ☐ **CareCredit**

Authorization and Release

I authorize the dentist to release any information (including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care) to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
Signature of patient (or parent/guardian if minor) _____

In order to comply with the privacy laws of the state of Illinois, we require written consent from you, the patient, before we can disclose your private health information to a family member or any other person you designate. Your signature on this document verifies that you are aware of the privacy law as stated above and agree to give your authorization to disclose your private health information to the person or persons you designate below.
This office ☐ **MAY disclose my information to** _____

☐ **MAY NOT disclose my information**

_____ _____

Patient Signature **Date**