

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 _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____
to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Co-payment due at time of appt.

Cash Personal Check VISA MasterCard American Express Discover CareCredit

Authorization Release

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