FAMILY DENTAL CARE OF Oak Park

Patient Registration Information

last name | first name | middle initial

date | patient #

street | apt. #

city | state | zip

birthdate | home phone number | work phone number

email address

Do you prefer to receive calls at: ○ work ○ home ○ either ○ email

Are you: ○ minor ○ single ○ married ○ divorced ○ widowed ○ separated

Your or your parent's employer _____

Occupation _____

Business address _____

City/State/Zip _____

Phone _____

Spouse or parent's name _____

Spouse or parent's employer _____

Work phone _____

If you are a student, name of school/college _____

City/State/Zip _____

Whom may we thank for referring you?

_____

Person to contact in case of an emergency _____

Phone _____

Address _____

City/State/Zip _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship _____

Home phone _____

Address _____

City/State/Zip _____

Social Security # _____

Driver's License # _____

Birthdate _____

Employer _____

Work phone _____

Is this person currently a patient in our office? ○ yes ○ no

INSURANCE INFORMATION

Name of insured _____

Relationship to patient _____

Birthdate _____ Social Security # _____

Date employed _____ Employer _____

Work phone _____

Address of employer _____

City/State/Zip _____

Insurance company _____

Group # _____

Insurance company address _____

City/State/Zip _____

ADDITIONAL INSURANCE

Do you have additional insurance? ○ yes ○ no

If yes, please complete the following:

Name of insured _____

Relationship to patient _____

Birthdate _____ Social Security # _____

Date employed _____ Employer _____

Work phone _____

Address of employer _____

City/State/Zip _____

Insurance company _____

Group # _____

Insurance company address _____

City/State/Zip _____

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependants during the period of such dental care to third-party payors and/or other healthcare practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all remaining balances.

signature of patient or responsible party (if minor) date

Thank you for filling out this form completely. The information you have supplied will help us provide your dental healthcare more effectively and efficiently. If you have any questions at any time please do not hesitate to contact us.

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