Dental Smiles of West Loop

1202 W MADISON STREET,CHICAGO,IL,60607 312.724.7161

PATIENT INFORMATION

Name: First_____Middle_____Last_____

Address: _____City_____State_____Zip_____

Cell Phone:_____Home Phone_____Work Phone_____

Where do you prefer to take calls? Work Cell Home Phone Email

Address:_____

SS #_____Drivers's License#_____State_____ Birthday_____

Employer_____Business Address_____Occupation_____

If College Student : Name of School _____City/State_____

Patient or Parent's Employer_____Business Address_____

Spouse's or Parents Name_____ Who can we thank for referring?_____

RESPONSIBLE PARTY

Name of person responsible for this account_____Relationship to patient_____

Address_____Phone #_____

Address of Employer _____

Is this patient currently a patient at our office? Yes No

INSURANCE INFORMATION

Name of Insured_____Relationship to the Patient_____

Subscriber Birthday_____Subscriber SS#_____

Employer_____Business Address_____

Insurance Co._____Phone #___(_____)_____

Group #_____Subscriber ID #_____

Do you have additional insurance ? YES NO IF YES PLEASE COMPLETE THE FOLLOWING

Name of Insured_____

Insurance Co_____ Phone #_____

Subscriber ID #_____Group#_____

Patient Signature (parent , if minor) _____