WEST SUBURBAN DENTAL SPECIALISTS

(Please Print)

Today's date:	My General Dentist is:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is the patient covered by insurance? ❑ Yes ❑ No Your insurance carrier is?

Subscriber's name:	Subscriber's ID#/Subscriber SS#	Birth date: / /	Group no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance:	Subscriber's name:	Group no.:	Subscriber's ID/Subscriber SS#

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize West Suburban Dental Specialists or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*