

# LINCOLN PARK DENTAL SPECIALISTS

Patient Name: \_\_\_\_\_ Marital Status: M S D W

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Home:( ) \_\_\_\_\_ - \_\_\_\_\_ Work:( ) \_\_\_\_\_ - \_\_\_\_\_ Cell:( ) \_\_\_\_\_ - \_\_\_\_\_

E-Mail: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer Name: \_\_\_\_\_

## **PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN ABOVE)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Marital Status: M S D W

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone (Home): ( ) \_\_\_\_\_ - \_\_\_\_\_ (Work): ( ) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Address: \_\_\_\_\_

## **REFERRAL INFORMATION**

Whom may we thank for referring you to our office? \_\_\_\_\_

Who is your General Dentist? \_\_\_\_\_ Office Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

*Who may we contact in case of Emergency?* \_\_\_\_\_

*Relationship:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

## **INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Group Number/ Policy Number/ Plan Number \_\_\_\_\_ Primary Secondary (Circle One)

I authorize the release of all medical information necessary to process my claims and the release of this information necessary to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Lincoln Park Dental Specialist. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read the Notice of Privacy Practices for Lincoln Park Dental Specialists

**\*\*I give permission for the following person(s) to discuss my health information:** \_\_\_\_\_

\*\* Payment is due at the time of service, unless prior arrangements have been made with our office. We accept cash, personal checks, American express, Visa and MasterCard. If for any reason you are unable to keep an appointment, 48 hours notice must be given to avoid an additional fee. Default; Patient agrees to pay a monthly rate of 1.5% interest on all unpaid balances 90 days or older.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_