McHenry Dental Specialists

PATIENT INFORMATION

Patient Name: _____ Date: _____

Gender: □ Male □ Female Marital status: □ Married □ Single □ Child □ Other: _____

Birthdate: _____ Social Sec#: _____ Drivers lic#: _____

Home #: _____ Work #: _____ Ext: _____

Mobile #: _____ Email address: _____

Address: _____
Street City State Zip Code

Employer Name: _____ Occupation: _____

If Student, Name of School/College: _____

City: _____ State: _____ □ Full Time □ Part Time

Emergency Contact Name: _____ Relation: _____

Contact ph #: _____ Add'l Contact ph #: _____

REFERRAL INFORMATION

Who may we thank for referring you to our practice? □ Dentist: Dr. _____

□ Another patient: _____ □ Insurance □ Yellow Pages □ Other _____

RESPONSIBLE PARTY INFORMATION

(If patient is a child this MUST be the parent that brought the child to the office)

Name: _____ Relation to patient: _____

Gender: □ Male □ Female Marital status: □ Married □ Single □ Other: _____

Birthdate: _____ Social Sec#: _____ Drivers lic#: _____

Home #: _____ Work #: _____ Ext: _____

Mobile #: _____ Email address: _____

Address: _____
Street City State Zip Code

INSURANCE INFORMATION

PRIMARY: _____
Name of insurance plan

Name of Insured: _____ Relation to patient: _____

Insured Birth Date: _____ Insured's Contact Ph# : _____

Insured's Address: _____
Street City State Zip Code

Insured's ID# : _____ Group #: _____

Name of Insured's Employer: _____

SECONDARY: _____
Name of insurance plan

Name of Insured: _____ Relation to patient: _____

Insured Birth Date: _____ Insured's Contact Ph# : _____

Insured's Address: _____
Street City State Zip Code

Insured's ID# : _____ Group #: _____

Name of Insured's Employer: _____