Arbor Hills
DENTAL CARE

175 N. Milwaukee Avenue
Suite 200
Vernon Hills, IL 60061
(847) 955-9500
FAX (847) 955-9519
arborhillsdental.com

WELCOME! *The benefits of a healthy and happy smile are immeasurable. Our goal is to help you reach and maintain this. In order for us to properly evaluate your dental and medical health, we request that you fill out* ***all*** *parts of this registration form. We believe that the better we communicate, the better we can care for you.*

GENERAL INFORMATION

DR. MISS MR. MS. MRS. FIRST NAME MIDDLE NAME LAST NAME		BIRTHDATE	SOCIAL SECURITY #
DR. MISS MR. MS. MRS. NAME OF RESPONSIBLE PARTY—IF DIFFERENT FROM ABOVE	DRIVER'S LICENSE #	STATE	SOCIAL SECURITY #
RESIDENCE ADDRESS NUMBER STREET		E-MAIL ADDRESS	
CITY STATE ZIP CODE (AREA CODE) PHONE		PREFERRED MODE OF APPOINTMENT CONFIRMATION: PHONE / E-MAIL / TEXT MESSAGE	
OCCUPATION OF RESPONSIBLE PARTY	EMPLOYER		
BUSINESS ADDRESS NUMBER STREET			
CITY STATE ZIP CODE (AREA CODE) PHONE			
WHOM MAY WE THANK FOR REFERRING YOU TO US?			
IN CASE OF AN EMERGENCY, PERSON TO NOTIFY RELATIONSHIP (AREA CODE) PHONE			

INSURANCE INFORMATION—If you have any type of dental insurance, please complete the following section.

PATIENT SECTION

NAME AND ADDRESS OF INSURANCE COMPANY (AREA CODE) PHONE			
EMPLOYEE/SUBSCRIBER NAME	RELATIONSHIP TO EMPLOYEE (CHECK ONE): ___SELF ___SPOUSE ___CHILD ___OTHER	SEX: ___M ___F	IF FULL-TIME STUDENT—SCHOOL & CITY
DENTAL PLAN NAME GROUP NUMBER EMPLOYEE/SUBSCRIBER SOC. SECURITY #			
IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ___YES ___NO DENTAL PLAN NAME GROUP NUMBER			
NAME AND ADDRESS OF OTHER INSURANCE COMPANY (AREA CODE) PHONE			

IF YOU WANT US TO ACCEPT YOUR INSURANCE ASSIGNMENT, PLEASE SIGN BELOW.

I authorize the release of any necessary information regarding my dental health to my dental insurance companies. I hereby authorize payment directly to Arbor Hills Dental Care, P.C. of the group insurance benefits otherwise payable to me. I understand that I am fully responsible for any portion of my bill not paid by my dental insurance company within ninety days of a claim being submitted.

Signature:_____

I acknowledge that payment is due at the time of treatment, unless other arrangements are made in advance. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing an insurance claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature:_____ **Date:**_____