LOCKPORT DENTAL GROUP
230 E. 8TH ST., SUITE C
LOCKPORT, IL 60441

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name____
Last First MI (Preferred)

Birthdate_________________ SS#______________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone__________________ Work Phone____________________ Cellular Phone__________________

Email____

Are you filling this out on the patient's behalf? [ ] Y [ ] N

If yes, name and relationship to patient____

Preferred contact method [ ] Home [ ] Work [ ] Cell

Preferred contact method for confirmations [ ] Home [ ] Work [ ] Cell

Preferred contact method for recall [ ] Home [ ] Work [ ] Cell

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS

Check box if same for entire family [ ]

Address____

Address 2____

City________________________________ State________Zip_____________________

PRIMARY INSURANCE

Patient's relationship to subscriber: [ ] Self [ ] Spouse [ ] Child SS#___________________ DOB______________

Subscriber Name____ Member ID # _______________________________

Insurance Company ____Phone________________________________

Address ____

Employer______________________________Group Name________________________Group #__________________

Please present insurance card and driver's license to receptionist.

SECONDARY INSURANCE

Patient's relationship to subscriber: [ ] Self [ ] Spouse [ ] Child SS#___________________ DOB______________

Subscriber Name____ Member ID # _______________________________

Insurance Company ____Phone________________________________

Address ____

Employer______________________________Group Name________________________Group #__________________

Signature ____ Date________________________