CHICAGO | SMILES

227 W. Monroe Street, Suite 205
Chicago, IL 60606

Welcome To Our Office!

For us to serve you properly, please complete this form. All information will be kept confidential.

Patient's Name	How should we address you	Birthday	Single Married Widowed Divorced
Patient's Full Address Street City Zip			Home Phone#
Patient's E-Mail Address (we will confirm your appointments by email)			Cellular Phone#
Name of Employer	Employer's Address		Office Phone#
Social Security#	Driver's License#	Occupation	
Do you have dental insurance? Yes No	If No, how would you pay? Cash, Credit Card, Check, Care credit (ask for details)	If Yes, Dental insurance provider's name	
Name of Policy Holder		Policy and Group#	
Policy Holder's Address (if different from above)		Policy Holder's SS #	Policy Holder's Birthday
Person financially responsible for account	Address if different from above		Phone # (home, cell, work)
Nearest friend / relative not residing with you	Relation to patient		Phone # (home, cell, work)
Who referred you to our office?			

Patient's Signature: _____ **Date:** _____