Associates for General Dentistry, Ltd.
1307 N. Rand Road
Arlington Heights, IL 60004

AssociatesForGeneralDentistry.com

(847)392-4422

afgd1307@gmail.com

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone:* _____ _____ _____ _____ _____ _____
Home Work Ext Mobile Fax Other

Address:* _____ _____
* _____ * _____ * _____
City State Zip Code

Spouse or Responsible Party Information

The following is for:* ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name:* _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone:* _____ _____ _____ _____ _____ _____
Home Work Ext Mobile Fax Other

Address:* _____ _____
* _____ * _____ * _____
City State Zip Code

SS# is used for insurance purposes only

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Primary Insurance Information

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Do you have Secondary Insurance?

* ◯ Yes ◯ No

Secondary Insurance Information

Name of Insured: Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Whom may we thank for your referral?

*

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HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although the revocation will not be effective as to the disclosure of records whose release I have previously authorized or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

* ☐ By checking this box, I consent to the practice's use and disclosure of my protected health information to carry out treatment, payment activites, and healthcare operations.

Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I also understand, if applicable, that Associates for General Dentistry is submitting my insurance only as a courtesy to me, and that I am responsible for contacting them, as well as my insurance company, if there are any issues.

* ☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Response Date: _____