Forest City DENTAL

PATIENT INFORMATION

Name: _____ _____
Last First MI (Preferred Name)

Birth Date: _____ ◯ Male ◯ Female ◯ Married ◯ Single ◯ Divorced

Address: _____
Street City, State Zip

Social Security #: _____ Email: _____

Phone (Home): _____ Phone (Cell): _____

(Work): _____- Ext.____ Best time to call: _____

Person Responsible for Account

Name: _____ _____
Last First MI (Preferred Name)

Birth Date: _____ ◯ Male ◯ Female ◯ Married ◯ Single ◯ Divorced

Address: _____
Street City State Zip

Social Security #: _____ Email: _____

Phone (Home): _____ Phone (Cell): _____

(Work): _____- Ext.____ Best time to call: _____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment

Employer Name: _____ Phone:_____

Primary Insurance Information

Name: _____ Birth Date: _____
Last First MI

ID #: _____ Group #: _____

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

Insurance Plan Name/ Address: _____
Street City, State Zip Phone

1855 Daimler Rd - Rockford, Illinois 61112 - 815.397.7454 - info@forestcitydental.net - forestcitydental.net

Forest City
DENTAL

Secondary Insurance Information

Name: _____ Birth Date: _____
Last First MI

ID #: _____ Group #: _____

Insured's Address: _____
Street City, State Zip Phone

Insured's Employer Name: _____

Insured's Employer Address: _____
Street City, State Zip Phone

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

I authorize my insurance benefits be paid directly to Forest City Dental. I understand that Forest City Dental PC has the right to charge my account for fees that may incur due to not keeping my reserved appointment time. I understand that I am responsible for any and all fees on my account. In the event my account is placed with a Collection Agency I understand I am responsible for all collection agency fees. In addition I will be responsible for all court costs, filing fees and attorney fees should my account require litigation.

Signature:_____ **Date:**_____

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