

Winning Smile

Dental Group, L.L.C.

PATIENT REGISTRATION FORM

2500 Ridge Avenue
Suite 102
Evanston, Illinois 60201
Phone: 847-869-1272
Fax: 847-869-7824



PATIENT INFORMATION

Mr. Mrs. Ms.	FIRST NAME	M.I.	LAST NAME	AGE	Marital Status	M	W	S	D
					Birthdate				
					Number of Dependents				
HOME ADDRESS					E-MAIL ADDRESS				
CITY	STATE		ZIP	Work Phone:	SOCIAL SECURITY NO.				
				Home Phone:					
EMPLOYER NAME					EMPLOYER ADDRESS			PHONE	
					CITY	STATE	ZIP		
Relationship to responsible party: Self, Spouse, Child, Other					Referred by:				

RESPONSIBLE PARTY INFORMATION FOR MINORS (parents or guardian)

Mr. Mrs. Ms.	FIRST NAME	M.I.	LAST NAME	NICKNAME	Marital Status	M	W	S	D
					Birthdate				
					Number of Dependents				
HOME ADDRESS					MAILING ADDRESS IF DIFFERENT				
CITY	STATE		ZIP	Work Phone:	SOCIAL SECURITY NO.				
				Home Phone:					

DENTAL INSURANCE INFORMATION

PATIENT'S INSURANCE Group

INSURANCE COMPANY OR MANAGED CARE (HMO) COMPANY			INSURANCE COMPANY / MANAGED CARE COMPANY ADDRESS		
POLICY HOLDER NAME		POLICY HOLDER'S BIRTHDATE	PERSONS COVERED		
EMPLOYER OF POLICY HOLDER			SOCIAL SECURITY NO. OF POLICY HOLDER		

SPOUSE'S INSURANCE Group

INSURANCE COMPANY OR MANAGED CARE (HMO) COMPANY			INSURANCE COMPANY / MANAGED CARE COMPANY ADDRESS		
POLICY HOLDER		PERSONS COVERED			
EMPLOYER NAME			EMPLOYER ADDRESS		PHONE
			CITY	STATE	ZIP

MISCELLANEOUS INFORMATION

Emergency Notification	NAME	ADDRESS	RELATIONSHIP	PHONE
Emergency Notification	NAME	ADDRESS	RELATIONSHIP	PHONE

I hereby authorize release of any information, including the diagnosis and records of treatments or examinations rendered, to my insurance company or managed care company. I also acknowledge being informed of Winning Smile Dental Group's Privacy Policy in accordance with the Department of Health and Human Services' Health Insurance Portability and Accountability Act.

Date _____

Signed _____