

PATIENT INFORMATION FORM

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Name: _____ Nickname: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email (for appointment reminder): _____ Sex: Male or Female
Name of school patient attends: _____
Whom may we thank for referring you?: _____
Does your child have siblings?: _____ If so, names & ages: _____

Responsible Party

Name of person responsible for this patient: _____ Relationship to patient: _____
Address (if different from above): _____ City: _____ State: _____ Zip: _____
Home phone: _____ Cell Phone: _____
Birth Date: _____ Social Security: _____
Email Address: _____ Marital Status: _____

Insurance Information

Name of Insured: _____ Relationship to patient: _____
Birthdate: _____ Social Security: _____ Date Employed: _____
Insured Party's Address: _____ City: _____ State: _____ Zip: _____
Name of employer: _____ Occupation: _____ Work Phone: _____
Insurance Co: _____ Tel #: _____ Group#: _____ Policy/ID#: _____
Amount of your Deductible: _____ Max Annual Benefit: _____
Do you have any additional insurance?: (circle one) YES NO If yes, complete the following:
Name of insured: _____ Soc. Security #: _____ Date Employed: _____
Name of Employer: _____ Union or local#: _____ Work phone: _____
Employer address: _____ City: _____ State: _____ Zip: _____
Insurance Co. _____ Tel#: _____ Group #: _____ Policy/ID#: _____
Insurance Co Address: _____ City: _____ State: _____ Zip: _____
Amount of your Deductible: _____ How much have you used?: _____ Max Annual Benefit _____

In my absence, I give permission to: _____ to accompany my child and consent for any needed treatment.

You agree that by checking the Electronic Signature such action will constitute your electric signature having the same legal force and effect as a hand written signature

Signature of patient (or parent, if minor) _____