Rockton Dental Care, P.C.
815-624-2626

Patient Information

Patient Name:______________________________ Date:__________
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security #:____________________ Birth Date:__________

Phone (Home):__________(Work):__________- Ext.: ______Best time to call:______

Phone (Cellular):__________Email:____________________

Address:____
Street City, State Zip Code

Person Responsible for Account

Name:______________________________
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced

Social Security #:____________________ Birth Date:__________

Phone (Home):__________(Work):__________- Ext.: ______Best time to call:______

Phone (Cellular):__________Email:____________________

Address:____
Street City, State Zip Code

Employment Information

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

Employer Name:____________________ Position:____________________

Address:____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________
Last, First MI

Insured's Birth Date:__________ ID #: __________Group #; __________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______

Insurance Plan Name / Address:

____
Street City, State Zip Code Phone

Secondary

Name of Insured: ______________________________
Last, First MI

Insured's Birth Date:__________ ID #: __________Group #; __________

Insured's Address:____
Street City, State Zip Code Phone

Insured's Employer Name: ______________________________

Address: ______________________________
Street City, State Zip Code Phone

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______

Insurance Plan Name / Address: ______________________________

____
Street City, State Zip Code Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Rockton Dental Care. I understand that I am financially responsible for any balance.

Signature: X______________________________**Date**__________