

WELCOME TO OUR OFFICE

REGISTRATION

GARY M. LAMANTIA, D.D.S.
RICHARD C. MAZANEK, D.D.S.
7942 WEST OAKTON STREET
NILES IL 60714-2457

Today's Date _____

Thank you for choosing our office.

In order to serve you properly we will need the following information. (Please print.) All information will be strictly confidential.

Patient's Name _____ Birth Date _____

How do you wish to be addressed _____ Email Address _____

Single Married Separated Divorced Widow/Widower

Name of spouse/partner _____ Birth Date _____

Street address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Patient employed by _____ Cell Phone _____

Business address _____

Present position _____ How long held _____

Purpose of the appointment _____

In case of emergency, who should be notified? _____ Phone _____

Person responsible for account _____ Relationship _____

Patient's Social Security number _____ Spouse's Social Security number _____

WHO MAY WE THANK FOR THIS REFERRAL

DENTAL INSURANCE – PRIMARY

Insurance plan holder's name _____ Birth Date _____

Employer _____ Number of years _____

Name of insurance company _____ Phone Number _____

Social security number/ID number _____ Group number _____

DENTAL INSURANCE – SECONDARY

Insurance plan holder's name _____ Birth Date _____

Employer _____ Number of years _____

Name of insurance company _____ Phone Number _____

Social security number/ID number _____ Group number _____

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Signature _____ Date _____