

JOSHUA H. EHRLICH, DMD PC
3118 N. Sheffield Ave. Ste. 1N, Chicago IL 60657
(773) 935-0300

REGISTRATION FORM

(Please Print)

Reason for visit (Circle all that apply): Cleaning Emergency Second Opinion Whitening Other

PATIENT INFORMATION

Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr. <input type="checkbox"/> Ms.	Marital status (circle one) Single / Married	
Is this your preferred name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your preferred name?	Email address:			Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:					All phone numbers:		
Drivers license no.:		City:		State:		Zip code:	
Occupation:		Employer:			Social Security Number:		
Chose Dr. Ehrlich because/Referred by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Website
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for payment	Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:			Employer phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance					
<input type="checkbox"/> Indemnity	<input type="checkbox"/> PPO	<input type="checkbox"/> Other			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Joshua H. Ehrlich, DMD PC. I understand that I am financially responsible for any balance. I also authorize this office or insurance company to release any information required to process my claims. Finally, I affirm that I have been offered and read the Office Privacy Policy according to HIPAA.

Patient/Guardian signature

Date