Prairie Dental, Ltd.
23909 W. Renwick Rd.
Plainfield, IL 60586

Patient Information

Date_____

Email_____

Patient_____

Address_____

_____

City_____ State_____ Zip_____

CONTACT INFORMATION

Home #_____

Work#_____

Cell#_____

Sex: ☐ M ☐ F Age:_____ Birthdate_____

☐ Single ☐ Married ☐ Divorced ☐ Seperated

Patient SS#

_____

Occupation_____

Spouse's SS#_____

Occupation_____

Employer_____

Whom may we thank for referring you?

_____

EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name_____

Phone Number: _____

Dental Insurance

Subscriber's Name

_____

Birth date _____SS#_____

Relation to Patient_____

Insurance Co.

_____

Group#

_____

Employer_____

Address_____

Is patient covered by addition insurance?

☐ Yes ☐ No

Subscriber's Name

_____

Birth date_____ SS#_____

Insurance Co.

_____

Group#

_____

Employer_____

Address_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with- _____ and assign directly to Dr. P. Lukawski, D.D.S all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

_____

Relationship _____ **Date** _____