LAKEVIEW
ORAL MAXILLOFACIAL SURGERY & MED SPA

1628 W. Belmont Ave.
Chicago, IL 60657
Phone (773) 327-9500 Fax (773) 327-3080
Email: lakeviewsurgery@yahoo.com

DOWNTOWN
ORAL MAXILLOFACIAL SURGERY

111 N. Wabash Ave * Suite 1801
Chicago, IL 60602
Phone (312) 929-2070 Fax (312) 846-6504
Email: downtownoralsurgery@yahoo.com

PATIENT REGISTRATION

Please complete this form and return to staff on the day of your appointment or fax / email to our office before appointment.

Patient Name: _____

Address: _____ Apt# _____ City: _____ Zip Code: _____
Primary Phone # _____ Email _____
Sex ○ Male ○ Female Birth Date: _____ SS#: _____
How did you hear about our office (If referred by dentist please let us know name of doctor): _____

EMERGENCY CONTACT

Who do we notify in case of an emergency: _____ PH#: _____

DENTAL INSURANCE INFORMATION

Dental Insurance Company: _____
Dental Insurance Group #: _____ Dental Insurance ID # _____
Employee Name (If other than patient please fill out): _____
Birth Date: _____ SS#: _____
Employer's Name: _____

MEDICAL INSURANCE INFORMATION

Medical Insurance Company: _____
Medical Insurance Group #: _____ Medical Insurance ID # _____
Employee Name (If other than patient please fill out): _____
Birth Date: _____ SS#: _____
Employer's Name: _____

I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR ALL DENTAL SERVICES RECEIVED FROM THIS OFFICE FOR MYSELF AND MY DEPENDENTS IS MINE, PAYABLE AT THE TIME SERVICES RENDERED, UNLESS PREVIOUS ARRANGEMENTS ARE MADE. DENTAL INSURANCE COVERAGE VARIES. PLEASE READ YOUR CURRENT POLICY TO FAMILIRAZE YOURSELF WITH YOUR INSURANCE COVERAGE. AS PART OF OUR SERVICE, WE TAKE GREAT EFFORT TO ASSIST YOU AND PROCESS YOUR CLAIMS.

SIGNATURE: _____ **DATE:** _____