PATIENT REGISTRATION FORM

MICHIGAN AVENUE DENTAL ASSOCIATES

MICHIGAN AVENUE GENERAL DENTAL ASSOCIATES

MICHIGAN AVENUE DENTAL SPECIALTY ASSOCIATES

Suite 1212
122 South Michigan Avenue, Chicago, Illinois 60603

PATIENT INFORMATION

Mr. Mrs. Ms. FIRST NAME M.I. LAST NAME AGE	Marital Status M W S D Birthdate Number of Dependents
HOME ADDRESS	E-MAIL ADDRESS
CITY STATE ZIP	Work Phone: Home Phone: SOCIAL SECURITY NO.
EMPLOYER NAME	EMPLOYER ADDRESS PHONE
	CITY STATE ZIP
Relationship to responsible party: Self, Spouse, Child, Other	Referred by:

RESPONSIBLE PARTY INFORMATION FOR MINORS (parents or guardian)

Mr. Mrs. Ms. FIRST NAME M.I. LAST NAME NICKNAME	Marital Status M W S D Birthdate Number of Dependents
HOME ADDRESS	MAILING ADDRESS IF DIFFERENT
CITY STATE ZIP	Work Phone: Home Phone: SOCIAL SECURITY NO.

DENTAL INSURANCE INFORMATION

PATIENT'S INSURANCE Group

INSURANCE COMPANY OR MANAGED CARE (HMO) COMPANY	INSURANCE COMPANY / MANAGED CARE COMPANY ADDRESS
POLICY HOLDER NAME POLICY HOLDER'S BIRTHDATE	PERSONS COVERED
EMPOLYER OF POLICY HOLDER	SOCIAL SEDCURITY NO. OF POLICY HOLDER

SPOUSE'S INSURANCE Group

INSURANCE COMPANY OR MANAGED CARE (HMO) COMPANY	INSURANCE COMPANY / MANAGED CARE COMPANY ADDRESS
POLICY HOLDER	PERSONS COVERED
EMPLOYER NAME	EMPLOYER ADDRESS PHONE
	CITY STATE ZIP

MISCELLANEOUS INFORMATION

Emergency Notification	NAME	ADDRESS	RELATIONSHIP	PHONE
Emergency Notification	NAME	ADDRESS	RELATIONSHIP	PHONE

I hereby authorize release of any information, including the diagnosis and records of treatments or examinations rendered, to my insurance company or managed care company. I also acknowledge being informed of Michigan Avenue Dental Associates' Privacy Policy in accordance with the Department of Health and Human Services' Health Insurance Portability and Accountability Act.

Date ____________________________ Signed ____