WILMETTE DENTAL
Peter Neuhaus | DDS

REGARDLESS OF INSURANCE COVERAGE, PAYMENT IS EXPECTED AT TIME OF SERVICE.

PATIENT INFORMATION

Title_____ First Name_____ Initial_____ Last Name_____

Nickname_____ Date of Birth_____/_____/_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Social Sec. #_____ Who Referred You To Us? _____

Employer_____ Occupation_____

Work Address_____ City_____ State_____ Zip_____

Marital Status (please circle) S M W D Email Address_____

PERSON RESPONSIBLE FOR PAYMENT (if different from above)

Title_____ First Name_____ Initial_____ Last Name_____

Social Sec. #_____ Date of Birth_____/_____/_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Employer_____ Occupation_____

Work Address_____ City_____ State_____ Zip_____

DENTAL INSURANCE INFORMATION

Do you have Dental Insurance? Yes No ***Please present your Insurance Card to our Receptionist.***

I acknowledge that I will be personally responsible for any and all charges. I understand that recovery from third party insurances is my responsibility and not the responsibility of the dentist. I agree to pay any amount not paid by my insurance company within thirty (30) days from the date of service.

I further agree to pay a service fee of 1.5% per month, which will be assessed on any unpaid balance after 30 days.

_____ _____

Signature of Person Responsible for Payment *Date*

Patient's Acknowledgment of Receipt of Notice of Privacy Policy

(You May Refuse to Sign This Acknowledgement)

I have received a copy of the Notice of Privacy Policy for the office of Wilmette Dental, Ltd.

Signature: _____Date:_____