

# 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: \_\_\_\_\_