General & Cosmetic Dentistry
1439 W. Fullerton Ave. Chicago, IL 60614
Office Ph. # 773 – 935 – 9818 / Fax # 773 – 935 – 9844

Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to contact us.

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Dr. Allen P. Momongan, DDS

PATIENT INFORMATION

Patient's Account # ______________

Name____ D.O.B.____/____/____ S.S.N_____-_____-_____
LAST FIRST M. INITIAL

How would you like to be addressed? ________________ (Maiden Name) ______________________
IF APPLICABLE

Home Address: ____ Apt. /Unit # ____________________
City________________________ St.________ Zip Code__________ Hm. Ph. ______-______-______
Cell Ph.______-______-______ E-mail Address: ____

Do you prefer for us to: Text Message________ E-mail________ to confirm your appointments?

Please Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Employer__________________________ Wk Ph ______-______-______ Ext.________
Employer's Address:________________________ City______________ St.______ Zip Code:__________

If Patient is a Student, Name of School/College________________________ City ____________ St.______

Emergency Contact ________________________ Relationship ____________ Ph. ______-______-______

Whom May We Thank for Referring You? ____

RESPONSIBLE PARTY & INSURANCE INFORMATION

Please Check Appropriate Box:
☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Partner

PRIMARY CARRIER

Name of Subscriber:____________________________
D.O.B._____/_____/_____ S.S.N_____-_____-_____
Home Address____________________________
HOME ADDRESS IF DIFFERENT FROM ABOVE
City ______________ St. ______ Zip Code __________
Home OR Cell Ph. ________-________-__________
Employer ________________ Wk Ph. _____-_____-_____
Ins. Co.______________________ Grp______________
ID# ______________________ Ph. _____-_____-_____

Please Check Appropriate Box:
☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Partner

SECONDARY CARRIER

Name of Subscriber: ____________________________
D.O.B._____/_____/_____ S.S.N _____-_____-_____
Home Address____________________________
HOME ADDRESS IF DIFFERENT FROM ABOVE
City ________________ St. ______ Zip Code __________
Home OR Cell Ph. __________-__________-__________
Employer __________________ Wk Ph. _____-_____-_____
Ins. Co.__________________________ Grp#__________
ID# ______________________ Ph. _____-_____-_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services.
I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
I attest to the accuracy of the information on this page.
Our office reserves the right to charge a fee for any cancelled or broken appointment without 24 hours notice.
This cancellation fee and any service fees can be increased at any given time.
Our office reserves the right to charge a $25.00 fee for any Release of Records.
We also reserve the right to a 1.5% finance charge for all outstanding accounts over 90 days.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN__________________________ DATE __________

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