Rockton Dental Care, P.C.
815-624-2626

Patient Information

Patient Name:_____ **Date**:_____
Last, First MI **(Preferred Name)**
☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Social Security #:_____ **Birth Date**:_____
Phone (Home):_____**(Work):**_____- **Ext**.: _____
Phone (Cellular):_____**Email**:_____
Address:_____
Street City, State Zip Code

Employment Information

Employer Name:_____ **Position**:_____
Address:_____
Street City, State Zip Code Phone

Person Responsible for Account (if not patient)

Name:_____
Last, First MI (**Preferred Name)**
☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced
Social Security #:_____ **Birth Date**:_____
Phone (Home):_____**(Work**):_____- **Ext**.: _____
Phone (Cellular):_____**Email:**_____
Address:_____
Street City, State Zip Code

Insurance Information

Primary
Name of Insured:_____
Name of Employer _____
Last, First MI
Insured's Birth Date:_____ **SSN#**_____ **ID #:** _____**Group** #_____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
_____
Insurance Plan Name / Address:
_____
Street City, State Zip Code Phone

Do you have secondary Insurance?_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Rockton Dental Care. I understand that I am financially responsible for any balance

Signature: X_____**Date**_____