DENTAL REGISTRATION AND HISTORY
(PLEASE PRINT)

HUGH MARCHMONT-ROBINSON, D.D.S., S.C.

3302 GROVE AVENUE • BERWYN, ILLINOIS 60402
Telephone: (708) 788-8200

PATIENT INFORMATION

Date ______________________ Home Phone (_____) ______________

Name ______________________ Soc. Sec. # ______________
Last Name First Name Initial

Address ______________________

City ______________ State ______ Zip ______

Sex ☐ M ☐ F Age_____ Birthday __________ ☐ Student ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ______________ Occupation ______________

Business Address ______________ Business Phone (_____) ______________

City ______________ State ______ Zip ______

Whom may we thank for referring you? ______________

In case of emergency who should be notified? ______________ Phone (_____) ______________

PRIMARY INSURANCE

Person Responsible for Account ______________________
Last Name First Name Initial

Relation to Patient ______________ Birthday __________ Soc. Sec. # ______________

Address (If different from Patient's) ______________ Phone (_____) ______________

City ______________ State ______ Zip ______

Person Responsible Employed by ______________ Occupation ______________

Business Address ______________ Business Phone (_____) ______________

City ______________ State ______ Zip ______

Insurance Company ______________

Group # ______________ Subscriber # ______________

ADDITIONAL INSURANCE

Is patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber Name ______________ Relation to Patient ______________ Birthday ______________

Address (if different from patient's) ______________ Phone (_____) ______________

City ______________ State ______ Zip ______

Subscriber Employed by ______________ Business Phone (_____) ______________

Insurance Company ______________ Soc. Sec. # ______________

Group # ______________ Subscriber # ______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to **HUGH MARCHMONT-ROBINSON, D.D.S., S.C.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ ______________ ______________
Responsible Party Signature Relationship Date

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PATIENT INFORMATION / INFORMATION DEL PACIENTE

NAME / NOMBRE ____________________ TODAY'S DATE / FECHA DE HOY ____________

ADRESS / DOMICILIO ____________________

CITY / CIUDAD ____________________ ZIP CODE / C.P. ____________

HOME PHONE (   ) ____________ CELL PHONE (   ) ____________

DATE OF BIRTH / FECHA DE NACIMIENTO ____________ AGE / EDAD ______ SOCIAL SECURITY # / NUMERO SS ____________

Sexo: ☐M ☐F Edad ☐Soltero(a) ☐Casado(a) ☐Viudo(a) ☐Separado(a) ☐Divorciado(a)

EMPLOYMENT / EMPLEO

EMPLOYER / NOMBRE DE EMPLEO ____________________ OCUPATION ____________

ADDRESS / DIRECION ____________________ CITY ____________ ZIP CODE / C.P. ____________

TELEPHONE / TELEFONO (   ) ____________

RESPONSIBLE PARTY OR INSURED / PERSONA PESPONSIBLE O ASEGURADA

NAME / NOMBRE ____________________

RELATION TO THE PATIENT / RELATION AL PATIENTE ____________________ OCUPATION ____________

DATE OF BIRTH / FECHA DE NACIMINTO ____________ SOCIAL SECURITY # / NUMERO SS ____________

NAME OF EMPLOYER / NOMBRE DE EMPLEO ____________________

TELEPHONE / TELEFONO (   ) ____________ EXT ______ CELL (   ) ____________

La informacion de arriba es correcta y completa, a mi leal saber y entendery firmo directo a el **Dr Hugh Marchmont - Robinson D.D.S., S.C.** procesamiento ante el seguro de los beneficios a los que tengo derecho. Yo no hare responsable a mi dentista ni a ningun integrants de su personal por errores que yo pueda haber cometido al llenar este formulario.

Fecha ____________________ Firma ____________________