Joshua H. Ehrlich, DMD PC

3118 N. Sheffield Ave. Ste. 1N, Chicago IL 60657
(773) 935-0300

REGISTRATION FORM

(Please Print)

Today's date:	Time:

PATIENT INFORMATION

Last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Dr. ❑ Ms.	Marital status (circle one) Single / Mar / DP

Is this your preferred name? ❑ Yes ❑ No	If not, what is your preferred name?	Email address:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	All phone numbers:

Drivers license no.:	City:	State:	Zip code:

Occupation:	Employer:	Social Security Number:

Chose Dr. Ehrlich because/Referred by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Website

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(**Please give your insurance card to the receptionist.)**

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

❑ Indemnity	❑ PPO	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Joshua H. Ehrlich, DMD PC. I understand that I am financially responsible for any balance. I also authorize this office or insurance company to release any information required to process my claims. Finally, I affirm that I have been offered and read the Office Privacy Policy according to HIPAA.

Patient/Guardian signature *Date*