MARTIN A. HIRSCH, DMD

Art + Science for your teeth

2800 North Sheridan Road ◆ Suite 204 ◆ Chicago ◆ 60657 ◆ 773.248.6140 ◆ 773.248.4628 Fax
www.martinahirschdds.com ◆ drmartinhirsch@gmail.com

Today's Date: _______________

PATIENT INFORMATION

PATIENT NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH	DRIVERS LIC #	SOCIAL SECURITY #

SEX M ☐ F ☐	EMPLOYER	OCCUPATION	REFERRED BY

RESIDENCE ADDRESS: NUMBER/STREET	CITY	STATE	ZIP CODE

BUSINESS ADDRESS: NUMBER/STREET	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	BUSINESS PHONE	EMAIL ADDRESS

MARITAL STATUS	SPOUSE'S NAME (If married)	SPOUSE'S EMPLOYER	SPOUSE'S OCCUPATION

BENEFITS

INSURANCE COMPANY	NAME OF POLICY HOLDER	GROUP NUMBER	CERTIFICATE NUMBER

RELATIONSHIP TO POLICY HOLDER	DATE OF BIRTH OF POLICY HOLDER	SOCIAL SECURITY SS# (OF POLICY HOLDER)	INS. COMPANY TOLL FREE #

FINANCIAL RESPONSIBILITY

PARTY RESPONSIBLE FOR BILL (If not patient)	RELATIONSHIP TO PATIENT	PHONE

RELATIONSHIP TO POLICY HOLDER	DATE OF BIRTH OF POLICY HOLDER	SOCIAL SECURITY SS# (OF POLICY HOLDER)	INS. COMPANY TOLL FREE #

RESPONSIBLE PARTY ADDRESS: NUMBER/STREET	CITY	STATE	ZIP CODE

IN CASE OF EMERGENCY WHO SHALL WE CONTACT	TELEPHONE	RELATIONSHIP

I understand that I have the primary duty to pay my doctor for services even though a portion of the fees may be payable or reimbursable by an insurance company or other third party payer.

I further understand that the determination of the dental care to be given me by my doctor and the fees to compensate for that care are matters between my doctor and myself. These fees are due at the time that services are rendered; any balance due longer than sixty (60) days from the date of service will be assessed at the rate of 1.5% per month as a service charge.

I hereby authorize Martin A. Hirsch, D.M.D., to release to my insurance company or other third party payer or its representative any information including the diagnosis and the records of any treatment or examination rendered to me.

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Witness Signature of Patient