About the Patient

McGonigle Dental Associates
17519 80th Avenue • Tinley Park, IL 60477 • www.mcgonigledental.com • (708) 429-2111

Date:_____

Patient Name: _____ Preferred Name: _____

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

DOB: _____ SSN: _____-_____-_____ Email: _____

Phone: Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Zip: _____

OK to text you with any appointment information? ☐ Yes ☐ No

How did you hear about our office? _____

or whom may we **thank** for referring you? _____

Other family members seen by McGonigle Dental Associates? _____

Employer Information

Employer Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Who Should We Contact in the Unlikely Event of an Emergency?

Name: _____ Relationship: _____

Phone: Home: _____ Work: _____ Cell: _____

Primary Dental Coverage

Policy Holder Name: _____ Policy Holder DOB: _____

ID#: _____ Group #: _____

Policy Holder Address: _____ City: _____ Zip: _____

Policy Holder Employer Name: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____ Effective Date: _____

Insurance Address: _____ Insurance Phone: _____

_____ Policy Holder SSN: _____-_____-_____

About the Patient

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Secondary Dental Coverage

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

ID#: _____ Group #: _____

Policy Holder Address: _____ City: _____ Zip: _____

Policy Holder Employer Name: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____ Effective Date: _____

Insurance Address: _____ Insurance Phone: _____

_____ Policy Holder SSN: _____-_____-_____

Person Responsible for Bill (If under the age of 18)

Name: _____ Title: Mr/Ms/Mrs/etc _____

Preferred Name: _____

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single

DOB: _____ SSN: _____-_____-_____ Driver's License: _____

Email: _____

Phone: Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Zip: _____

I understand McGonigle Dental Associates will provide me with an estimate of the dental treatment recommended by my doctors. I understand that limitations and exclusions may exist in my dental plan that have not been disclosed to McGonigle Dental Associates by my dental carrier. I understand that I am responsible for any unpaid balance in full.

Initials: _____

The information I have given on the About the Patient form is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Print Name: _____

Guarantor Signature (if patient under age 18)

Signature: _____ Date: _____

Print Name: _____

Relationship: _____