Arnold K. Chernoff, D.D.S.

636 Church St.
Suite 304
Evanston, IL 60201

Patient Information

Date_____

Patient's Name_____
Last First Middle

Preferred Name _____ Marital Status_____

Whom may we thank for referring you to us?_____

Are you satisfied with the appearance of your teeth?_____

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____

Work Phone_____ **Email**_____

Birthdate_____ SS#_____

Employer_____ Occupation_____ Yrs. Employed____

Responsible Party Information

Name_____
Last First Middle

Address_____
Street City State Zip

Years at this address____ Home Phone_____ Work Phone_____

SS# _____ Birthdate_____ Relation to patient_____

Employer_____ Occupation_____ Yrs. Employed_____

Spouse's Name_____
Last First Middle

Spouse's Employer_____ Occupation_____ Phone_____

Signature

1. I authorize the release of information to all my insurance carriers.
2. I authorize payment directly to my doctor.
3. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
4. I understand that I am responsible for my bill.
5. I understand payment is due at time of service unless other financial arrangements are made.

Name_____

Signature_____ Date_____