MOUNT PROSPECT SMILES
A HEALTHY SMILE TO FIT YOUR LIFESTYLE

847 392 4270
847 590 1896
info@mpsdentist.com
www.MountProspectSmiles.com

NEW PATIENT FORM

DATE	NAME (LAST)	(FIRST)	(M.I.)	EMAIL ADDRESS

BIRTHDATE (MONTH/DAY/YEAR)	AGE	SEX	MARITAL STATUS	SOCIAL SECURITY #

ADDRESS	CITY	STATE / ZIP CODE

HOME/CELL PHONE	WORK PHONE	OCCUPATION	HOW LONG EMPLOYED

EMPLOYER	ADDRESS	STATE

DENTAL INSURANCE	MEMBER NO. I.D.	GROUP NO.

HOW DID YOU HEAR ABOUT US?

RESPONSIBLE PARTY /SPOUSE INFORMATION

(Please Print)

NAME LAST	FIRST	M.I.

BIRTHDATE (MONTH/DAY/YEAR)	AGE	SEX	SOCIAL SECURITY#

EMPLOYER	PHONE

ADDRESS	CITY	STATE / ZIP CODE

OCCUPATION	HOW LONG EMPLOYED

DENTAL INSURANCE CO.	TELEPHONE	GROUP NO.	MEMBER ID

IN CASE OF EMERGENCY CONTACT:	TELEPHONE

I certify the above information is true and correct to the best of my knowledge. I have given ALL of my insurance coverages. I understand if I knowingly present a false or fraudulent claim, I am financially responsible. I understand I am financially responsible for any balance.

I, ______________________ hereby consent to any dental necessary services from Mount Prospect Smiles for myself or my minor child. By my signature below, I also acknowlege that I have read and been offered a copy of the Mount Prospect Smiles Notice of Privacy Practices.

Signature   Date

CELL PHONE / EMAIL CONSENT:
I consent to Mount Prospect Smiles using my cell phone number and email to provide information regarding treatment, insurance, account, appointment reminders and other educational/promotional items. ____________ (initials)