William J. Becker DDS
2630 New Sutton Road
Hoffman Estates, IL 60192
847-884-8484 phone 847-884-8486 fax
www.poplardentalcenter.com

Name:____
Last First M.I.

Date of Birth:___/____/____ Sex: ☐ Male ☐ Female SSN:____________________________
Mailing Address:__________________________ City:___________________ State:_______ Zip:________
Home Phone: ( )_________________ Work : ( )________________ Cell: ( )_____________________
E-Mail: _________________________________ Marital Status: _________________________________

Referred By:____
Primary Care Physician:________________________________ Phone: ( )________________________

PARENT, SPOUSE, OR RESPONSIBLE PARTY (If different from patient)
Name:____
Last First M.I.
Mailing Address:____
Home Phone: ( )_________________ Cell : ( )________________

INSURANCE CARRIER INFORMATION
Primary Insurance Carrier:_____________________________ I.D.#_______________________________
Policy Holder's Name__________________________ Date of Birth__________________________________
Secondary Insurance Carrier:__________________________ Policy Holder Name____________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name___________________ Occupation___________________ Employer's Name_________________
Address___________________________ City____________________ __State___ Zip_______________
Phone Number______________________________

YOU

Name___________________ Occupation___________________ Employer's Name_________________
Address___________________________ City____________________ __State___ Zip_______________
Phone Number______________________________ Fax Number_________________________________

YOUR SPOUSE

Name___________________ Occupation___________________ Employer's Name_________________
Address___________________________ City____________________ __State___ Zip_______________
Phone Number______________________________ Fax Number_________________________________

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EMERGENCY CONTACT INFORMATION

In case of Emergency, who should be notified?____
Relationship________________________________ Phone: (   ) ________________________________
Do you give our office permission to discuss your medical information with family members?
YES____ NO____   If yes, please provide their names and phone numbers below.

May we leave personal information on your answering machine or cell phone?_____________________

I hereby authorize Poplar Crossing Dental to release information regarding care tendered. Should an Insurance claim be filled by Poplar Crossing Dental, I authorize payment of benefits to go directly to Polar Crossing Dental. I understand that I will be responsible for any and all charges not covered by my insurance company.

____

Signature   Date

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CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ______________________'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I have given consent to the doctor's or designated staff use and disclosure of an oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 ½ % late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature____ Date___________________

Parent/Responsible Party's Signature_________________________ Relationship to Patient____________