Wheaton Cosmetic Dentistry

1275 E. Butterfield Rd., #202
Phone: 630-653-5152 Fax: 630-653-5380

Patient Information

Name _____ Today's Date _____
Address _____ City _____ State_____ Zip _____
E-Mail _____Home Phone _____ Date of Birth _____
Work Phone _____ Cell Phone _____ Drivers License # _____
Social Security # _____ ___ Minor ___ Single ___ Married ___ Divorced
Patient's or Parent's Employer Name _____ Work Phone # _____
Business Address _____ City _____ State_____ Zip _____
Person to contact in case of emergency _____ Phone _____
WHO MAY WE THANK FOR REFERRING YOU? _____

Responsible Party (Only fill out if different than above)

Name of Person Responsible for this Account _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Birth date_____
Social Security # _____ Employer _____
Business Address _____ City _____ State _____ Zip _____

Dental Insurance Information **(This information is for the subscriber – not necessarily the patient)**

Name of Insured _____ Relationship _____
Birth date _____ Social Security # _____ Work Phone _____
Name of Employer _____ Employer Address _____
City _____ State _____ Zip _____
Dental Insurance Company _____ Group# _____ /ID_____
Insurance Phone # _____ Insurance Address _____
City _____ State _____ Zip _____
How much is the: Deductible? _____ Yearly Max _____ How much has been used this year? _____

CONSENT: The undersigned patient hereby authorizes the Doctor to take x-rays or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. Patient authorizes the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. Patient acknowledges and accepts the risk associated with anesthetic agents. Patient shall pay for all treatment(s) incurred, with or without the Patient's signature. In the event that the patient fails to make payment when due, Patient shall pay, in addition to the invoice amount, a late charge of 1 ½ percent per month. Late payment charges shall be construed in such a manner as to be enforceable under the pertinent state law (including but not limited to classification as "interest" and liquidated damages"). Patient agrees to pay all cost of collection by the Doctor of any amounts due hereunder, including actual attorney's fees. If patient is a minor, the parent or guardian of the minor agrees to be responsible for all treatment(s) received by a minor. If a credit card is provided, Patient authorizes Doctor to apply all past due amounts to the credit card provided. Patient agrees to assign all dental insurance benefits to the Doctor.

VISA MC DISCOVER AMEX _____exp date_____ Security Code _____

Patient Signature (Parent if Child) _____ Date_____/_____/_____

Dentist Signature_____ Date_____/_____/_____