



Grayslake Orthodontics, PC

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Patient Name: _____ Birth Date: ____/____/____ Male / Female
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Cellular Phone: _____
Nickname: _____ Current Age: _____ Employer: _____
Marital Status: Single / Married / Divorced / Widowed
If Patient is a Minor:
Current Grade: _____ Siblings: _____ Pets: _____
Last Dental Visit: ____/____/____ Special Interests: _____

Who may we thank for referring you to our office?: _____

Account Information

Responsible Party: _____ SSN: ____ - ____ - ____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone:(____) _____ Relation to Patient: _____ Birth Date: ____/____/____
Employer: _____ Job Title: _____ Work Phone:(____) _____
Employer Address: _____ City: _____ State: ____ Zip: _____
Cellular: _____ Email: _____
Spouse: _____ SSN: ____ - ____ - ____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone:(____) _____ Relation to Patient: _____ Birth Date: ____/____/____
Employer: _____ Job Title: _____ Work Phone:(____) _____
Employer Address: _____ City: _____ State: ____ Zip: _____
Cellular: _____ Email Address: _____

Dr. Hertzberg may use my/my child's photos and/or x-rays for demonstration purposes. I understand that my name and other private information will be protected at all times.

Over →

Insurance Information

As a courtesy our office can submit insurance claims on your behalf. Please fill this consent form completely.

- I do NOT have dental insurance. (Please sign below for consent purposes.)
- We have dual dental insurance. The information below is: Primary / Secondary (Circle One - We will need a form completed for the other insurance.)

Insured's Name: _____ Birth Date: ____/____/____
SSN: ____ - ____ - ____ Insured ID #: _____
Home Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Cellular #: _____ Relationship to Patient: _____
Employer's Name: _____ Work Phone: _____
Work Address: _____
City: _____ State: ____ Zip: _____ Position: _____
Insurance Company: _____ Ins Co Phone: _____
Ins Co Address: _____ City: _____ State: ____ Zip: _____
Group or Plan #: _____ Policy #: _____
Union Name: _____ Local #: _____

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by Grayslake Orthodontics and will keep them informed if changes occur in the health or other information that I have provided herein. I authorize Grayslake Orthodontics to submit insurance claims on my behalf, if applicable, and assume financial responsibility for the total fee charged, as the insurance plan is a contract between myself and my insurance carrier (not between Grayslake Orthodontics and my insurance company).

Signature: _____ Date: _____

For Office Use Only:

Verified: _____

Date

Ins Contact: _____ Phone: _____ Eff Date: _____ Calendar Yr?: Y/N _____

Is deductible combined with Basic, Major, & Ortho _____ has it been met for this year? _____

Orthodontic Coverage: _____ % Deductible: \$ _____ Applies? Y / N Age Limits: _____ Space Maint: _____ %

Is turn around form (BCBS) or pre-determination letter sent to verify ongoing treatment? _____ Age

Limit _____ Ded _____

Ortho Pymt Schedule?: _____ % at Banding: _____ % LT Max: _____ Used: _____ Dental Yrly Max: _____

Metlife-Do related procedures apply?(circle) yes or no Delta (circle) Preferred or Premier

PPO Provider?: Y / N Resubmit Required? Y / N (Monthly / Quarterly) Verified Address?: Y / N

