



## Grayslake Orthodontics, PC

David R. Hertzberg, D.D.S., M.S.  
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Grayslake, IL 60030  
(847)548-4330 / Fax (847)548-4335

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: \_\_\_\_\_

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## 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

