

PATIENT REGISTRATION

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ID: _____ Chart ID _____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient Is: Policy Holder Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ ext _____

Cellular: (____) _____ Pager: (____) _____

Birth Date: _____ Social Security (Soc Sec.) Number: _____

Drivers License: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ ext _____

Cellular: (____) _____ Pager: (____) _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Last Dental Visit: _____

Referred By: _____

Emergency Contact: _____

Phone: (____) _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00