WELCOME

To
The Dental Practice of Lincoln Park
General & Cosmetic Dentistry
Dr. Allen P. Momongan, DDS / Dr. Matthew D. Flak, DDS
2551 N. Clark – Suite 501, Chicago, IL 60614
Office Ph. # 773 – 935 – 9818 – Fax # 773 – 935 – 9844

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

PATIENT INFORMATION

Patient's Account # ______________

Name_______________________________________ D.O.B._____/_____/_____ S.S.#______-_____-______
LAST FIRST INITIAL
How would you like to be addressed? __________________ (Maiden Name) __________________________ IF APPLICABLE
Home Address: ____ Apt./Unit # _________
City________________________ St.___________ Zip Code__________ Hm. Ph. #_____-_______-_______
Cell Ph. #______-______-______ E-mail Address:____
Do you prefer for us to: Text Message_____, E-mail_____, or Both ______ to confirm your appointments?
Please Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Employer______________________________ Position____________ Wk Ph #_____-_____-_____ Ext.#_____
Employer's Address:____________________________ City______________ St._____ Zip Code:___________
If Patient is a Student, Name of School/College________________________ City _______________ St._______
Whom May We Thank for Referring You? ____
Emergency Contact__________________________ Relationship ____________ Ph. # ______-______-_______

RESPONSIBLE PARTY / INSURANCE INFORMATION:

Please Check Appropriate Box: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Partner
Name of Subscriber___________________________ D.O.B.______/_____/_____ S.S.# ______-______-______
****HOME ADDRESS IF DIFFERENT FROM ABOVE****
Home Address_______________________________________ Apt. / Unit #_________
City ________________________ St. _____ Zip Code _________ Hm. Ph. # ______-______-______
Cell Ph. #_______-______-_______ E-Mail Address: ____
Employer ____________________________ Position ____________ Wk Ph. # _____-_____-_____ Ext. ______
Employer's Address ______________________________ City _____________ St. _____ Zip Code __________
Insurance Company____________________ Group#_______ ID# _______________ Ph.# _____-_____-_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services.
I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
I attest to the accuracy of the information on this page.
Our office Policy reserves the right to charge a $45.00 fee for any cancelled or broken appointment without 24 hours notice.
This cancellation fee and any service fees can be increased at any given time.
We also reserve the right to a 1.5% finance charge for all outstanding accounts over 90 days.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN____________________________ DATE _________