We are happy you are here!

CONTOS SMILE CENTER
6428 N. California Avenue
Chicago, IL 60645
773-973-0531

Patient Registration

(Please print clearly)

Patient Information Today's Date: _____

Patient's Name: _____ DOB: _____/_____/_____
Last First MI Age: _____

Social Security #:_____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name:_____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Email Address: _____

What is your **preferred** method of communication? ☐ Phone ☐ Cell ☐ Work ☐ Email

Are you ok with receiving text messages from us? **YES NO**

Who may we thank for referring you?_____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip:_____

Responsible Party

Name: _____ Relationship to patient: _____

DOB: _____/_____/_____ Social Security#:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Cell: (_____) _____

Primary Insurance Information:

Primary Policy Holder:_____ Relationship to Patient:_____

Insurance Company:_____ P.O. Box:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____/_____/_____ Subscriber ID: _____ Group#: _____

Phone Number customer service:_____