COLONIAL DENTAL ASSOCIATES, LTD.

1660 Feehanville Dr, Suite 250. Mount Prospect, IL 60056

PATIENT'S INFORMATION

(CONFIDENTIAL INFORMATION FOR OUR FILES)

- PLEASE PRINT CLEARLY -

SOC. SEC. NO. _____

NAME _____ AGE _____ BIRTH DATE _____
LAST NAME MR./MRS./MISS/MS. FIRST NAME

RES. ADDRESS _____ RES. PHONE _____
STREET CITY STATE ZIP

BUS. ADDRESS _____ BUS. PHONE _____
STREET CITY STATE ZIP

EMPLOYED BY _____ OCCUPATION _____

REFERRED BY _____ PHYSICIAN _____

SPOUSE'S NAME _____ NO. OF DEPENDENTS _____

SPOUSE'S BUS. ADDRESS _____ BUS. PHONE _____
STREET CITY STATE ZIP

PERSON FINANCIALLY RESPONSIBLE _____ OCCUPATION _____

RES. ADDRESS _____ RELATIONSHIP _____

NAME OF GROUP DENTAL PLAN _____ RES. PHONE _____

ALL CHARGES ARE 29 DAY ACCOUNTS - 1 1-1/2% BILLING FEE WILL BE ADDED TO 30 DAY & OVER ACCOUNTS

SIGNED _____ DATE _____