



About the Patient

McGonigle Dental Associates
17519 80th Avenue • Tinley Park, IL 60477 • www.mcgonigledental.com • (708) 429-2111

Date: _____

Patient Name: _____ Preferred Name: _____

Gender: Male Female Family Status: Married Single Child Other _____

DOB: _____ SSN: _____ - _____ - _____ Email: _____

Phone: Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Zip: _____

OK to text you with any appointment information? Yes No

How did you hear about our office? _____

or whom may we **thank** for referring you? _____

Other family members seen by McGonigle Dental Associates? _____

Employer Information

Employer Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Who Should We Contact in the Unlikely Event of an Emergency?

Name: _____ Relationship: _____

Phone: Home: _____ Work: _____ Cell: _____

Primary Dental Coverage

Policy Holder Name: _____ Policy Holder DOB: _____

ID#: _____ Group #: _____

Policy Holder Address: _____ City: _____ Zip: _____

Policy Holder Employer Name: _____

Patient's Relationship to Policy Holder: Self Spouse Child Other _____

Insurance Plan Name: _____ Effective Date: _____

Insurance Address: _____ Insurance Phone: _____

Policy Holder SSN: _____ - _____ - _____



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Secondary Dental Coverage

Policy Holder Name: _____ Policy Holder DOB: ____/____/____
 ID#: _____ Group #: _____
 Policy Holder Address: _____ City: _____ Zip: _____
 Policy Holder Employer Name: _____
 Patient's Relationship to Policy Holder: Self Spouse Child Other _____
 Insurance Plan Name: _____ Effective Date: _____
 Insurance Address: _____ Insurance Phone: _____
 _____ Policy Holder SSN: _____ - _____ - _____

Person Responsible for Bill (If under the age of 18)

Name: _____ Title: Mr/Ms/Mrs/etc _____
 Preferred Name: _____
 Gender: Male Female Family Status: Married Single
 DOB: _____ SSN: _____ - _____ - _____ Driver's License: _____
 Email: _____
 Phone: Home: _____ Work: _____ Cell: _____
 Address: _____ City: _____ Zip: _____

I understand McGonigle Dental Associates will provide me with an estimate of the dental treatment recommended by my doctors. I understand that limitations and exclusions may exist in my dental plan that have not been disclosed to McGonigle Dental Associates by my dental carrier. I understand that I am responsible for any unpaid balance in full.

Initials: _____

The information I have given on the About the Patient form is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Print Name: _____

Guarantor Signature (if patient under age 18)

Signature: _____ Date: _____

Print Name: _____

Relationship: _____