124 W. Northwest Highway
Palatine, IL 60067
p: (847) 481 - 8400
f: (847) 481 - 8909

Patient Information

Thank you for choosing Clock Tower Dentistry. Please complete this form in ink and print your answers.
If you have any questions, please do not hesitate to ask one of our staff.

Name ______________________________ Date ___/___/___
First Name MI Last Name

Address ______________________________
City ______________ State ________ Zip ________
Birthdate ___/___/___ ☐ Male ☐ Female Home Phone# (____) ____________
Cell Phone# (____) ____________ Work Phone# (____) ____________
Where do you prefer to take calls: ☐ Home ☐ Cell ☐ Work
May we contact you by E-mail? ☐Yes ☐ No E-mail Address ______________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor
Social Security # ____/____/____ Drivers License # ____________ State ______
Employer ______________ Occupation ______________
Business Address ______________________________
City ______________ State ________ Zip ________
Spouse's Name ______________ Workplace ______________
If you are a student, name of school ______________ City/State ______________
How did you hear about our office? ______________________________
Who may we thank for referring you? ______________________________
Emergency Contact ______________ Phone# (____) ____________

Responsible Party *(if patient is a minor)*

Name of person financially responsible for this account ______________
Relationship to patient ______________ Phone # (____) ____________
Address of Employer ______________________________
City ______________ State ________ Zip ________

Insurance Information

Name of Insured ______________ Relationship to Patient ______________
Subscriber Birthdate ___/___/___ Subscriber Social Security # ______________
Employer ______________ Occupation ______________
Business Address ______________________________
City ______________ State ________ Zip ________
Insurance Co. ______________ Group # ______________
Subscriber ID # ______________________________
Insurance Co. Address ______________________________
City ______________ State ________ Zip ________
Insurance Company Phone # (____) ____________

Do you have additional dental insurance? ☐ Yes ☐ No If yes, Please complete the following:
Insurance Co. ______________ Group # ______________
Subscriber ID # ______________________________
Insurance Co. Address ______________________________
City ______________ State ________ Zip ________
Insurance Company Phone # (____) ____________