



# Irwin C. Mishoulam, D.D.S.

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## Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-Mail \_\_\_\_\_ Home Phone \_\_\_\_\_ Birth date \_\_\_\_\_  
Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Social Security # \_\_\_\_\_ Minor \_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced  
If student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Patient's or Parent's Employer Name \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_  
WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

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## Responsible Party (Only fill out if different than above)

Name of Person Responsible for this Account \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Birth date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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## Payment Options

YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED. ANY BILLED CHARGES INCLUDING UNPAID INSURANCE WILL INCURE FINANCE CHARGES OF 1.5% PER MONTH STARTING 30 DAYS FROM THE DATE OF SERVICE. TO AVOID FINANCE CHARGES, PLEASE PAY AT TIME OF SERVICE. WE OFFER THE FOLLOWING METHODS OF PAYMENT. PLEASE CHECK THE OPTION (OPTIONS) YOU PREFER:

Cash  Check  Visa  MasterCard  Discover  American Express

PAYMENT IN FULL AT EACH APPOINTMENT IS EXPECTED FOR ALL NON-INSURED PATIENTS, AND CO-INSURANCE PATIENTS. ACCOUNTS SENT TO COLLECTIONS ARE LIABLE FOR ALL COSTS. **I agree to the above terms and conditions.**

Signature \_\_\_\_\_

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## HIPAA Notice (To be completed in the office.)

I have read/received a copy of the HIPPA privacy notice as required by law.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Dental Insurance Information

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Employer Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ /ID \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_ Insurance Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_