Grayslake Orthodontics, PC
David R. Hertzberg, D.D.S., M.S.
160 Commerce Drive, Suite 101
Grayslake, IL 60030
(847)548-4330 / Fax (847)548-4335
www.GrayslakeOrtho.com

Patient Name ________________________ Preferred Name ____________________ Male/Female

Address ___________________________ City ________________ State _____ Zip ________

Birth Date ____/_____/_____ Home Phone ____________ Siblings ______________________

Who may we thank for referring you to our office? ____________________________________

Account Information

Responsible Party____ SSN_____-_____-________

Address ______________________________ City ________________ State ___ Zip _______

Home Phone ________________ Relation to Patient _____________ Birth Date ____/_____/_____

Employer ____________________ Position _______________ Work Phone _______________

Employer Address _________________________ City ________________ State ____ Zip _______

Cell Phone ________________ Email ____

Marital Status: Single / Married / Divorced / Widowed

Responsible Party____ SSN_____-_____-________

Address ______________________________ City ________________ State ___ Zip _______

Home Phone ________________ Relation to Patient _____________ Birth Date ____/_____/_____

Employer ____________________ Position _______________ Work Phone _______________

Employer Address _________________________ City ________________ State ____ Zip _______

Cell Phone ________________ Email ____

Marital Status: Single / Married / Divorced / Widowed

Over →

Insurance Information

As a courtesy our office can submit insurance claims on your behalf. Please fill this consent form completely.

- ☐ I do NOT have dental insurance. Please sign below for consent purposes.
- ☐ I have one dental insurance policy which is the information below.
- ☐ I have dual dental insurance. The information below is: Primary / Secondary (Circle One)
  Another form will need to be completed for the other insurance.

Main Enrollee Name ____ Birth Date _____/______/_____

SSN ______-_____-________ Insured ID # ____________________ Relation to Patient ____________________

Home Address ________________________________ City ________________State ____ Zip __________

Home Phone ________________Cell Phone _________________ Email ______________________________

Employer's Name ____________________________________ Work Phone ______________________

Work Address ____

City ____________________State ____ Zip _________ Position ________________________________

Insurance Company ____________________________________ Ins Co Phone ______________________

Group # _________________________Union Name _______________________Local # _________________

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by Grayslake Orthodontics and will keep them informed if changes occur in the health or other information that I have provided herein. I authorize Grayslake Orthodontics to submit insurance claims on my behalf, if applicable, and assume financial responsibility for the total fee charged, as the insurance plan is a contract between myself and my insurance carrier (not between Grayslake Orthodontics and my insurance company).

Signature ____ Date ___________________________

For Office Use Only Date Verified ____________________

____

Contact ______________________ Phone __________________________ Eff Date _____________ Waiting Period_____________

Ortho Coverage _______% Deductible$ ________ /yr or one time Family Ded $_______ Met? Y / N

Is deductible combined with Basic, Major, & Ortho? Y / N Has it been met for this year? Y / N

Age Limits _______________ Banding ________% LT Max $___________ Used $ _____________ Remaining $________________

Ortho Pymt Schedule? Auto/ Not Auto (Monthly/ Quarterly/ Semi Annual/ Annual/ One Time) Resubmit Required? Y / N OR

Is there a form such as a voucher or pre-determination letter sent to verify ongoing treatment? Y / N

Metlife-Do related procedures apply? Y / N Delta (circle) Preferred or Premier

Dental Yrly Max_____________ Calendar Yr? Y/N__________ Space Maint_______% Age Limit_______ Ded _______ Met? Y/N

Claims Address_________________________________ City__________________ State____ Zip__________ Group#_____________