Jason J. Armstrong, DDS
SMILES
Of Orland Park

Thank you for choosing us as your Dental Healthcare Team! To help us meet all your dental healthcare needs, please provide us with the following information.

Patient Information (Confidential)

Date_____ Gender: (M/F) SSN_____

Name_____ DOB_____ Home Phone_____

Address_____ City_____ State___ Zip_____

Email address: _____ Texting: Yes__ No__ Cell Phone_____

Check appropriate: ___Minor ___Single ___Married ___Divorced ___Widowed ___Separated

Person to contact in case of an emergency_____

Whom may we thank for referring you_____

Responsible Party

Person Responsible for this account_____ Relationship to patient_____

Address_____ Home Phone_____

Employer_____ Work Phone_____

DOB_____ SSN_____

Insurance Information

Name of Subscriber_____ Relationship to Patient_____

Subscriber's DOB_____ SSN or ID#_____

Name of Employer_____ Work Phone_____

Insurance Company_____ Group#_____ Phone_____

Insurance Company_____ Address_____ City_____ State___ Zip_____

Do you Have Additional Insurance? Yes No If yes please complete the following:

Name of Subscriber_____ Relationship to Patient_____

Subscriber's DOB_____ SSN or ID#_____

Name of Employer_____ Work Phone_____

Insurance Company_____ Group#_____

Insurance Company Address_____ City_____ State____ Zip_____