



Patient Information

HomeRun Dental
3745 N Clark Street
Chicago, IL 60613
773-248-0300 Phone
773-248-0303 Fax
HomerunDental.com

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? _____
Closest relative not living with you & their phone number _____
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 # (____) _____