

Welcome to the office of
William L. Eick, D.D.S.

Please **fax the completed form to (440) 333-1614** or bring in the completed form with you on your first appointment.
Faxing the completed form ahead of time will save you time and help us be prepared for your visit.

PATIENT INFORMATION

Name: _____ I prefer to be called: _____
Date of Birth: ___/___/___ SSN: ___-___-___
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Marital Status: Single Married Divorced Widowed
Emergency Contact: _____ Relationship: _____ Phone: _____
Referred to us by: _____
Employer: _____ Occupation: _____
Work Phone Number: _____

ACCOUNT INFORMATION

Person Responsible for Account: _____ Relationship: _____
Date of Birth: ___/___/___ SSN: ___-___-___
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Employer: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____
Group Name: _____ Group Number: _____
Subscriber's Name: _____ Member ID #: _____ Birthdate: _____

Secondary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____
Group Name: _____ Group Number: _____
Subscriber's Name: _____ Member ID #: _____ Birthdate: _____