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:** __________

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Secondary Insurance Company: ____
Address: ____
City: ____ **State:** ______________ **Zip Code:** ____________
Phone: _________________________
Group Name: ____ **Group Number:** ____________________________
Subscriber's Name: ___________________ **Member ID #:** _________________ **Birthdate:** __________