Aurora Hills Dental

Family & Cosmetic Dentistry

John K. Zalesky, D.M.D.

Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____ SS# _____

Birthdate _____ Home# _____ Cell# _____

Email _____ Wk# _____

Address _____ City _____ State _____ Zip _____

When confirming appts how do you prefer to be contacted? ☐ Phone ☐ Email ☐ Text ☐ Msg

Spouse or Parent's Name _____ Phone# _____

How did you hear about our office? (Check all that apply)

☐ Google ☐ Website ☐ Drive By ☐ Mailer ☐ Other

☐ Patient _____

Person to Contact in Case of Emergency _____ Phone # _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____

Contact # _____ Birthdate _____ Employer _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Work# _____

Name of Employer _____ Insurance Co. _____

Group# _____ Policy/ID# _____ Customer Service # _____

Ins Co. Address _____ City _____ State _____ Zip _____

Authorization and Release I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

I agree to be responsible for payment of all service rendered on my behalf of myself and any dependents.

Signature of Patient (Parent if patient is a Minor) _____