Chesaning Family Dental - Patient Information

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If you have any questions, don't hesitate to ask.

Patient Name______________________ Date of Birth_____________ Sex______ Age______

Home address______________________ City________________ State_______ Zip_________

Home phone_______________ Cell_______________________ Work Phone________________

SS#______________________ Employer___________________ Email______________________

Spouse's name & phone__________________________ Emg phone_____________________

Primary Dental Insurance_________________________ ID & Group #____________________

Secondary Dental Insurance_______________________ ID & Group #____________________

Subscriber's Name______________________ Date of birth_____________ SS#_______________

Medical doctor____________________________ Date of last visit to medical doctor____________

Referred to us by____________________________________

Responsible Party

For your convenience, we offer the following methods of payment. Please Check the option you prefer. Payment in full at each appointment is expected.

Cash Personal Check Credit Card Office Financial Arrangements

Authorization

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that any dental plan I have is strictly a contract between me and my insurance carrier. As such, I agree to be responsible for full payment of services not paid in full within 60 days. I understand that I am responsible for all charges weather or not they are covered by insurance, as well as any additional costs, if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I understand that in certain circumstances, my credit report my be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted into automatic bank draft.

Signature____**Date**_______________________________

(989)845-7242 – 1109 West Broad Street – Chesaning, MI 48616