chesterfield hilltown dental

Patient Information

Patient Name: _____ Date: _____
Last First MI

I prefer to be called _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security # _____ Birth Date _____ E-mail Address _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Preferred Method of Communication: ☐ **Phone:** ☐ **Home** ☐ **Work** ☐ **Cell**
Check ALL that apply as okay to communicate. ☐ **Text** ☐ **Email**

Address: _____
Street Apartment #

_____
City State Zip Code

In the Event of an Emergency Contact: _____
Name Phone

Dental Insurance Information

Primary Insurance:

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary Insurance:

Name of insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Spouse / Parent Information

Name: _____ ☐ Male ☐ Female

Employer: _____ Occupation: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

Name of person or office referring you to our practice: _____

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

See Reverse Side ➡

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We should receive payment from the insurance company within 60 days.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor or his assignee at the time said services are rendered or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to the form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian (responsible party)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

you may refuse to sign this document

I, _____ , have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

Optional section

[sign only if you wish to give Chesterfield Hilltown Dental permission to disclose your dental health information to another person (family member, guardian...)]

List name(s) below. I reserve the right to change this list at any time.

1.

2.

3.

Signature _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify) _____