## **CHESTERFIELD DENTIST**

11601 Iron Bridge Road, Suite 204 Chester, Virginia 23831 Telephone (804) 717-5100

Date											

Name:			Nick Name:		Birth Date:	SSN:
(First)	(MI)					
Home Address:			City:		State:	Zip:
Home Phone:						
Marital Status: Single:						
If under 18, name of pa	arent/gua	ırdian:				
If full time student, nan	ne of sch	ool:			······································	
Employer Name:		City:	State:_	Zip:_	Phone:	
Spouse's name:		SSN#:	Birth	date:		
Closest Relative (not li	ving with	you): Name:			Phone:	· · · · · · · · · · · · · · · · · · ·
Address:			City:		State:	Zip:
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2) For patients with Dental Insurance, all co-payments and deductibles are due at the time of service. Insurance benefits are estimated as closely as possible. Patients are responsible for any fee not covered by insurance. This estimate does not constitute any promise of payment from the patient's insurance company; it is merely a reference for the patient.

## **Insurance Authorization and Assignment**

I hereby authorize Chesterfield Dentist to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance.

Furthermore, in the event that my account becomes delinquent, I will be responsible for any collection fees or Attorney fees that may be necessary for the collection of my account, and understand that the uncollected balance will be liable to a service charge of 1 1/2 % per month with an annual rate of 18%.

Signature:	Date:
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