CHESTERFIELD DENTIST

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

Date_____

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS

Name:_____Nick Name:_____ Birth Date:_____ SSN:_____
(First) (MI) (Last)
Home Address:_____City:_____State:_____Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone: _____Email: _____
Marital Status: Single:_____Married:_____ Divorced:_____ Widow:_____
If under 18, name of parent/guardian: _____
If full time student, name of school:_____
Employer Name:_____City:_____State:____Zip:_____Phone:_____
Spouse's name: _____SSN#:_____ Birth date:_____
Closest Relative (not living with you): Name:_____Phone:_____
Address:_____City:_____State:_____Zip:_____
Whom may we thank for referring you? _____Relationship:_____
Regarding your dental treatment:
Previously, have you ever had a bad experience at a dental office: _____ If yes, please specify: _____
Would you like to receive full dental care in our office? _____ If no, please specify:_____
Are you interested in nitrous oxide sedation? _____

Financial Responsibility

Name of Insured: _____Relationship to patient:_____
Name of Dental Insurance Company:_____Phone:_____
Address: _____City:_____State:_____Zip:_____
Group #:_____Subscriber ID#:_____Subscriber birth date:_____

Secondary Dental Ins: Name of Insured:_____Relationship to patient:_____
Name of Dental Insurance Company:_____Phone:_____
Address:_____City:_____State:_____Zip:_____
Group #:_____Subscriber ID#:_____Subscriber birth date:_____

Agreement

1) Payment is due when services are rendered. Payments can be made by cash, check, Visa, Master Card, Discover, American Express or by Care Credit.
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:**_____