Welcome to the office of Chalet Dental

We are complimented that you have selected us to provide dental care for you and your family.

Account #: Doctor:

Patient Name:

PATIENT INFORMATION

Mailing Address: City: State: Zip:

Male/Female: (circle one) Nickname:

Date of Birth: Social Security #:

Email Address:

Contact Person Not Living With Patient: Relationship:

This Contact Person's Address & Phone Number:

Whom May We Thank for Referring You? Are You Covered by Provider One? Yes No

FOR ADULT PATIENTS

Home Phone: Cell Phone:

Employer: Work Phone:

Occupation: How Long Employed?

Name of Spouse:

Spouse's Employer: Spouse's Occupation:

How Long Employed: Spouse's Work Phone: Spouse's Cell Phone:

Spouse's Social Security #: Spouse's Date of Birth:

PATIENT INSURANCE INFORMATION - PRIMARY COVERAGE

Subscriber Name: Employer:

Insurance Co.:

Insurance Co. Address:

Insurance Co. Phone #: Group#:

Subscriber's ID#: Subscriber's Birth Date:

Family Members Covered: Effective Date of Coverage:

PATIENT INSURANCE INFORMATION - SECONDARY COVERAGE (IF YOU HAVE DUAL COVERAGE)

Subscriber Name: Employer:

Insurance Co.:

Insurance Co. Address:

Insurance Co. Phone #: Group#:

Subscriber's ID#: Subscriber's Birth Date:

Family Members Covered: Effective Date of Coverage:

CONSENT FOR TREATMENT

Where appropriate and necessary, credit bureau reports will be obtained.

I hereby authorize Chalet Dental to administer any treatment and to perform such x-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

I authorize release of any information relating to this claim. I realize that I am ultimately responsible for all costs of dental treatment.

I hereby authorize my insurance benefits to be paid directly to Chalet Dental.

Date: _____ Signature: _____

After initial x-rays and examination, we will give you an estimate of fees to cover your treatment. At that time financial arrangements will be made before treatment is rendered.

Preferred method of payment: ____ Cash ____ Check ____ Credit Card ____ Care Credit