West Chester Center For Dentistry

PATIENT INFORMATION

Patient Name: ______________________________ Date: __________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: __________ Birth Date: __________ Cell #: __________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Driver's Lic#: __________ E-mail address: __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

REFERRAL INFORMATION

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

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

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

INSURANCE INFORMATION

Primary

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

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: __________

____

ASSIGNMENT OF BENEFITS

I agree to be responsible for all charges for dental sevices and materials not paid by my dental plan, unless prohibited by law, or the treating Dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent prohibited by law, I consent your use and disclosure of my protected health information to carry out payment activities in connection with my claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to West Chester Center for Dentistry.

Signature of insured: ______________________________ Date: __________

CONSENT FOR SERVICES

CONSENT:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Patient Signature (Parent of Child) ______________________________ Date: __________