CHEHALIS DENTAL CARE

Personal Information

Name ______________________________ SOC.SEC. # ______________________

Address______________________________ Home Phone______________ Cell______________

City ______________ State________ Zip __________ Email ______________________________

Sex □ M □ F Age________ Birthdate ______________ □ Single □ Married □ Other______________

Whom may we thank for referring you? ______________________________

In case of emergency, who should be notified? ______________________________ Phone ______________

Person responsible for account ______________________________

Last First Initial

Relationship ______________ Birth date ______________ SOC. SEC. # ______________

Address (if different then patient's) ______________________________ Phone ______________

City ______________________ State __________ Zip __________

Responsible party employed by ______________________________ Occupation ______________

Business address ______________________ Phone ______________ Cell ______________

Primary Insurance

Insurance company ______________________________

Subscriber ID # ______________________ Group # ______________________

Additional Insurance

Is the patient covered by additional insurance? □ YES □ NO

Subscriber name ______________________ Relationship to patient ______________ Birthdate __________

Address (if different from patient's) ______________________________ Phone ______________

City ______________________ State __________ Zip __________ Subscriber employed

by ______________________________ Business phone ______________

Insurance company ______________________________

Subscriber ID # ______________________ Group # ______________________

Method of payment

Which of the following methods of payment will you be using? I understand I am responsible for all costs relating to my treatment.

Method of payment: □ Cash □ Check □ VISA □ MC □ Discover □ Care credit

All information written is true and complete. Signature: ______________________________ DATE: ______________

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company as we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS: __________

HIPPA Acknowledge of Receipt of Notice of Privacy Practices

Share information with: Name: ______________________________ Relationship: ______________

Print Name: ______________________ Signature: ______________________________ Date: __________

**YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT □ Patient Refused to Sign HIPPA