

Chesterfield Family Dental

Welcome to Chesterfield Family Dental, Dr. Roger D. Buzbee

PATIENT INFORMATION:

Name _____ Date of Birth _____ Marital Status S M D W

Address _____ City _____ State _____ Zip code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Email Address _____ SSN _____ - _____ - _____

Can Appointments be confirmed by Email: Y N Can appointments be confirmed by Text: Y N

Please advise us who referred you to our office. _____

Spouse's Name _____ Date of Birth _____ Phone _____

OR

Parent/Guardian _____ Date of Birth _____ Phone _____

Address _____ City _____ State _____ Zip code _____

Emergency Contact _____ Phone # _____ Relationship _____

Insurance Information: *(please bring current dental insurance card and driver's license to appointments)*

Insurance Co Name _____ Phone # _____

Policy Holder Name _____ ID # _____

SSN _____ Date of Birth _____ Group # _____

Policy Holders Employer _____ Do you have other dental Insurance? Y N

Insurance Authorization Statement *(sign & date)*

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all fees's covered and/or not covered by my insurance. I understand that if my account is turned over to a collections agency due to non-payment, I will be responsible to pay all cost of collection, court and legal fees in addition to the balance owed. I hereby authorize the Dental Office to administer such medication and perform such diagnostic and therapeutic procedure as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

(If Patient is Under 18)

Responsible Party _____ Relation to Patient _____

Address _____ Phone _____