Chesterfield Family and Cosmetic Dental Center

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

PATIENT INFORMATION:

E-mail Address: _____Last Name: _____First Name:_____

Middle Initial: _____ Preferred to be called: _____ Address: _____

City, State, Zip code: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Can Appointments be confirmed by Email and Text? (Please circle one) Yes No Which is your preference? Email Text Both

Employer: _____ Occupation: _____

SS#: _____Sex: M F Marital Status: S M D W

In the event that we must contact you for scheduling changes, etc., please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____Place:_____Time:_____

Spouse's Name: _____Occupation: _____ Phone: _____

OR

Parent/Guardian: _____Occupation:_____ Phone:_____

Address: _____ City, State, Zip: _____

Emergency Contact: _____ Phone #: _____Relationship: _____

How did you hear about our office? Please check: ____Internet ____ Patient referral ____Website ____ Insurance Other _____

If you were a referral, whom may we thank for their trust in us? _____

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

Primary Insurance Co Name: _____Phone #: _____

Address: _____ City, State, Zip: _____

Policy Holders Name: _____ ID #: _____

SSN: _____ Date of Birth: _____ Group #: _____

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

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Chesterfield Family Dental of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ Patient/Responsible Party Signature: _____

Consent:

I hereby authorize Chesterfield Family Dental to take the necessary x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Chesterfield Family Dental to make a thorough diagnosis of the patient's dental needs, lab needs; and for the use of dental education, which may include full face or smile photos. I waive any claim which might accrue to me personally on the account of the use of such photographs, x-rays. I also authorize Chesterfield Family Dental to perform 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 my dental insurance is a contract between me and the insurance carrier and not between Chesterfield Family Dental and your insurance company. I fully understand that it is my financial responsibility only for the dental treatment regardless of insurance coverage. 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.

Signature: _____ Date: _____

If Patient is Under 18

Responsible Party: _____Relation to Patient: _____

Address: _____ Phone: _____