WELCOME TO CHESNEY DENTISTRY

Patient Name:	Social Security Number: - -	Birthdate: / /
Home Address	City, State, Zip	
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	Home Phone:	Cell Phone:
Email address:	Driver's License and State	Work Phone:
Dental Insurance Company	Group:	Subscriber:
Responsible Party Name:	Social Security Number: - -	Birthdate: / /
Home Address	City, State, Zip	
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	Home Phone:	Cell Phone:
Email address:	Driver's License and State	Work Phone:

Relationship to patient:	Responsible party's employer	Occupation
Business Address	City, State, Zip	

How did you hear about Chesney Dentistry?

How did you hear about Chesney Dentistry?

❑ Yellow Pages ❑ Sign by Building ❑ Online Search ❑Referred by a friend/relative

❑ TV/Radio Ad ❑ Magazine Ad ❑ Website ❑ Other _____

If you were referred, whom may we thank for referring you? _____

CONSENT

I will answer all health questions to the best of my knowledge. _____ (initials)

I have reviewed the information on this, and on the accompanying medical health questionnaire, and they are complete and accurate to the best of my knowledge. I understand that this information will be used by the dentist and hygienist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I authorize use of ditigal images, x-rays and photographs to be used for diagnostic and identification purposes; I also authorize and request the administration of any anesthetic and/or x-rays as may be deemed necessary and advisable by the doctor.

Signed: _____ Date: _____

TERMS AND CONDITIONS

I authorize the insurance company indicated on this form to pay to Chesney Dentistry any and all insurance benefits for services rendered. I authorize the use of this signature on all relevent insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for any and all charges, whether or not paid by insurance. The estimated financial responsibility of each patient will be made before treatment. As a condition of treatment by this office, I understand any financial arrangements must be made in advance, or the balance is due in full at the time of service. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid in full at the time the services are performed. If I carry insurance, I understand that this office will assist in billing my insurance benefit to help in obtaining reimbursement from insurance companies and will credit such reimbursement to my account. However, Chesney Dentistry cannot render services on the assumption that charges will be paid solely by an insurance company.

Assignment of Insurance: I authorize the release of medical/dental information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I understand that any fee estimate for dental care can only be extended for a period of 90 days. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I provide. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions (and conditions on reverse side) and agree to their content.

Signed: _____ Date: _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

Unpaid balances over 90 days may be placed with an outside collection service or attorney, at an additional cost. In the event that legal proceedings become necessary to resolve any unpaid balance, attorney fees and court costs involved with the collection of the outstanding balance will be the sole responsibility of the patient/responsible party. There will be a 23% APR service charge applied to any account with a balance over 90 days and a $25.00 fee for all returned checks.

I understand I am responsible for any and all charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection at a rate of 35% of the total bill in addition to the amount of the total bill if collection procedures be required.

Responsible Party / Patient Signature: _____ Date: _____