

**Welcome** to Chandler Dental Clinic! Thank you for trusting us with your child's dental care. Please complete this form in ink.

**Your Child**

Child's Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS# \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone H/C \_\_\_\_\_

**Responsible Party**

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_  
SS # \_\_\_\_\_ DL # \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Phone C/W \_\_\_\_\_

**Who is responsible for making appointments and bringing child?**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

List best numbers to call in order of preference and indicate cell, work, or home.

1) \_\_\_\_\_ C/W/H 2) \_\_\_\_\_ C/W/H 3) \_\_\_\_\_ C/W/H

**Mother**

stepmother  guardian

Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
SS # \_\_\_\_\_ DL# \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Marital Status: Single/Married/Divorced/Separated

**Father**

stepfather  guardian

Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
SS # \_\_\_\_\_ DL # \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Marital Status: Single/Married/Divorced/Separated

**Primary Insurance**

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_

**Additional Insurance**

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_

**Financial Arrangements**

Payment for services rendered is due in full at the time services are completed. For your convenience, we offer to bill your insurance for their estimated portion and accept cash, personal check or credit card for the remainder. Please be fully aware that you are responsible for any amount that is not paid or covered by your insurance, regardless of the circumstances for their non-payment.

## **Release of Information**

I authorize the release of any dental information to process this claim.

**X** \_\_\_\_\_ Date \_\_\_\_\_

## **Assignment of Benefits**

I authorize payment directly to the providing dentist for insurance benefits otherwise payable to me.

**X** \_\_\_\_\_ Date \_\_\_\_\_

Please note: Some procedures performed may not be covered by certain insurance plans, especially plans where benefits are determined by company/ employer fee schedules. Cost of treatment that is denied by insurance becomes the patient's responsibility. Your insurance does not furnish us with a specific fee schedule for your individual policy or group plan. We are only given a "general fee schedule" and can only estimate what your insurance will pay. To avoid unanticipated costs, it is your responsibility to be informed as to what your insurance plan will cover before treatment.

If we are a "Preferred Provider" for your insurance plan, the contracted fees we post to your account will only be estimates based from the "general fee schedule" provided by your insurance. When we receive a response to your claims, we will adjust the fees based on the statement sent to us by your insurance company. The fees that are posted (on the day service is provided) may be adjusted higher or lower depending on the benefits of your specific plan as determined by the insurance company. We are not furnished with this information prior to treatment. However, the final adjusted fees will never be higher than our standard fees.