



**Patient Name:** \_\_\_\_\_ **Preferred Name:** \_\_\_\_\_  
**Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Sex:** M  F   
**Marital Status:** Married/Single/Widowed/Divorced/Child **Email Address:** \_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Spouse/Parent:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Emergency contact person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### **Dental Insurance Information**

Please remember that insurance is considered a method of reimbursing the patient fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. As a courtesy we extend to our patients we will file your insurance claims. However all charges are your responsibility from the date services are rendered.

### **Primary Insurance** (Please give receptionist your card to copy)

**Policy Holder:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_  
**Insurance Company Name:** \_\_\_\_\_ **Policy ID#:** \_\_\_\_\_  
**Group#:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_  
**Claims Address:** \_\_\_\_\_

**Assignment of Insurance Benefits:** I hereby authorize my insurance benefits to be paid directly to *Scott M Chandler, DMD*. I am responsible for all services not covered. I authorize the release of any dental information and/or x-rays necessary to process any claim.

**\*\*\*Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Patient, legal guardian or authorized agent of Patient)

**Submit**