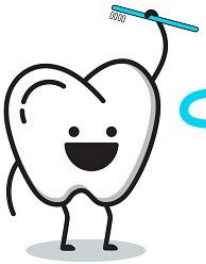

Chompers
pediatric & teen dentistry
Grow Up Smiling.

Date _____

PATIENT INFORMATION

Who may we thank for referring you? _____
Child's Name_____ Birthdate: _____ S. S.#_____
Child's Name_____ Birthdate: _____ S. S.#_____
Child's Name_____ Birthdate: _____ S. S.#_____
Child's Name_____ Birthdate: _____ S. S.#_____

Address_____ City_____ State_____ Zip_____
Home Phone _____ Cell Phone_____ Email Address_____
If Student, Name of School/College _____City _____State_____
___Part Time ___Full Time
Has anyone in your family been seen at our office location? If yes, who?_____
Person to Contact in Case of Emergency_____Phone_____

FAMILY INFORMATION

Does your family have any custody agreements in place through a court of law: Yes____ / NO_____
(If yes, our office will need a copy of this agreement upon arrival)

Parent or Legal Guardian Name_____ Birthdate:_____
S. S.#_____ (required for insurance and financial purposes)
Address _____City _____State _____Zip _____
Parent's Employer _____ Parent's Work Phone _____

Additional Parent or Legal Guardian Name _____ Birthdate:_____
S. S.#_____ (required for insurance and financial purposes)
Address _____City _____State _____Zip _____
Parent's Employer _____ Parent's Work Phone _____

DENTAL INSURANCE INFORMATION

Primary Insurance Information
Circle: Employer coverage (or) Individual plan
Subscriber Name _____ Birthdate:_____ S. S.#_____
Name of Employer _____
Insurance Company Name_____ Group #_____ Policy/ID #_____
Address _____City _____State _____Zip _____
Secondary Insurance Information
Circle: Employer coverage (or) Individual plan
Subscriber Name _____ Birthdate:_____ S. S.#_____
Name of Employer _____
Insurance Company Name_____ Group #_____ Policy/ID #_____
Address _____City _____State _____Zip _____

____ FINANCIAL INFORMATION – PLEASE READ CAREFULLY

- It is the goal of our practice to provide not only the finest care available, but also to provide financial services that do not cause undue hardships. Patients will be scheduled for treatment after financial arrangements are made with our finance coordinator regarding all treatment.
- OUR FINANCE COORDINATOR IS AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE.
- Our office requires a 24 hour notice if you are not able to make your appointment. If we do not receive this notice, a fee will be charged to your account.

____ X-RAY REQUIREMENTS

- We pride ourselves in delivering the highest standard of care; depending on your child's age and oral health, complete diagnostic x-rays may be necessary. If you have had this done with another dentist recently, we ask that you bring them with you on your initial visit**.**
- If you do not have them or are not able to retrieve them from your previous dentist before your appointment with us, we may need to take x-rays and bill you in order to fully assess your child's treatment needs.

____ INSURANCE POLICY

- All co-pays and deductibles are due at the time of service and in some cases may be required when scheduling an appointment for dental treatment. As a courtesy to all of our patients with insurance, we will file dental services with your primary insurance company, and if applicable your secondary insurance.
- The normal time allowed for insurance response is 30-45 days. Any charges remaining on your account after your insurance pays are ultimately your responsibility.

____ PAYMENT POLICY

- Our office requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the finance coordinator. If other arrangements are made, the patient, parent or guardian authorizes Chompers Pediatric & Teen Dentistry to make such inquiries with any credit bureau regarding financial responsibilities that are deemed necessary.

____ COLLECTION POLICY

- If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, interest charges, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of service once your account has been satisfied with the attorney.

____ AUTHORIZATIONS FROM PATIENT

- I authorize Chompers Pediatric & Teen Dentistry to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any required information to outside health practitioners and for the purpose of processing insurance claims.
- I understand that my insurance policy is a contract between me and my insurance companies and that I am responsible to Chompers Pediatric & Teen Dentistry for all fees.
- I authorize and request my insurance company, if applicable; to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual billed services and that I am responsible for the remaining balance.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I certify that all statements are true and correct, and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws

Parent or Guardian Signature _____ Date _____

I ALLOW THE FOLLOWING INDIVIDUALS TO DISCUSS MY CHILD'S FINANCIAL, MEDICAL AND/OR DENTAL INFORMATION WITH EMPLOYEES OF CHOMPERS PEDIATRIC & TEEN DENTISTRY.

PLEASE PRINT FULL NAMES: _____ _____