WELCOME!

Thank you for filling out this form completely. It will enable us to help you more effectively.

PATIENT INFORMATION

NAME: _____
Mr Mrs Ms Dr Last First Middle

I prefer to be called: _____ ☐ Male ☐ Female

__/__/__ _____ ___-___-___
Birthdate Age Social Security Number

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Street Address: _____

Mailing Address: _____

_____
City State Zip

Home # _____ Work # _____ Ext: _____

Cell # _____ Email _____

Where and when are the best times to reach you: _____

_____

EMPLOYER: _____

Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

OTHER INFORMATION:

Guarantor (person responsible for paying account): _____

_____

Relationship of patient to guarantor: _____

Who may we thank for referring you/How did you hear about us? _____

_____

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Home # _____ Work # _____ Ext: _____

SPOUSE INFORMATION

NAME: _____
Mr Mrs Ms Dr Last First Middle

Birthdate: __/__/__ SS #: ___-___-___

Cell # _____ Work # _____ Ext: _____

EMPLOYER: _____

Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Chase Family Dentistry
(509) 422-3200
108 2nd Ave South
PO Box 631
Okanogan, WA 98840

PARENT INFORMATION (for minors)

NAME: _____
Mr Mrs Ms Dr Last First Middle

Birthdate: __/__/__ SS #: ___-___-___

Cell # _____ Work # _____ Ext: _____

EMPLOYER: _____

Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Name of Insured: _____

☐ Self ☐ Spouse ☐ Other _____

Birthdate: __/__/__ SS #: ___-___-___

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Co. Phone #: (___) _____

SECONDARY DENTAL INSURANCE

Name of Insured: _____

☐ Self ☐ Spouse ☐ Other _____

Birthdate: __/__/__ SS #: ___-___-___

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Co. Phone #: (___) _____

OFFICE FINANCIAL POLICY:

For patients with Dental Insurance:
We will assist you with the initial claim for dental services. Payment of patient's percentage is expected at time of treatment. With approved credit, financial arrangements can be requested for the patient's percentage. A **12% finance charge** will be added to any balance after 60 days. I hereby authorize payment of all dental benefits otherwise payable to me, to be sent to Chase Family Dentistry. Upon receipt of insurance checks I will endorse and send them to Chase Family Dentistry.

For patients with no Dental Insurance:
Payment for dental services is expected at time of treatment. With approved credit, financial arrangements can be requested for the patient's percentage. A **12% finance charge** will be added to any balance after 60 days.

I authorize release of my records to specialists or insurance companies as deemed necessary.

_____ __/__/__
Patient/Parent/Guardian Signature **Date**