Chaska Dental CENTER

Welcome

Our mission at Chaska Dental Center is for each of our patients to achieve optimal dental health by providing only the highest level of care. We believe strongly in the correlation between a healthy mouth and body.

We are committed to pursuing excellence through continuing education, personal and team growth and mastery of leading edge technology. It is our goal to hold firmly the lasting relationships we have established with our patients, while looking forward to relationships yet to be built.

Patient Information - Child

Patient Name _____ **Preferred Name** _____

SSN _____ Sex M F DOB _____ Age _____

Address _____ SSN _____

City _____ State _____ Zip _____

Patient's School _____ Student Status PT FT

Whom may we thank for referring you to our office? _____

Parent Information

Parent Name _____ Relationship to Patient _____

Address _____ SSN _____

City _____ State _____ Zip _____ Drivers Lic. # _____

Home (_____)_____ Cell (_____)_____ Work (_____)_____

Sex M F DOB _____ Single Married Separated Divorced Widowed

Parennt's Employer/School _____ Student Status PT FT

Email Address _____ Occupation _____

How would you like to receive your confirmations/reminders? E-mail Text Messaging Postcard

Parent Name _____ Relationship to Patient _____

Address _____ SSN _____

City _____ State _____ Zip _____ Drivers Lic. # _____

Home (_____)_____ Cell (_____)_____ Work (_____)_____

Sex M F DOB _____ Single Married Separated Divorced Widowed

Parent's Employer/School _____ Student Status PT FT

Email Address _____ Occupation _____

How would you like to receive your confirmations/reminders? E-mail Text Messaging Postcard

Insurance Information

Will you be using dental insurance for your visit today? Yes No

If yes, please complete the insurance information below.

Primary Insurance Information

Subscriber _____ Relationship to patient _____ DOB _____

Employer _____ ID# _____ Group# _____

Insurance Company _____ Insurance Co. Phone _____

Insurance Co. Address _____

Secondary Insurance Information

Subscriber _____ Relationship to patient _____ DOB _____

Employer _____ ID# _____ Group# _____

Insurance Company _____ Insurance Co. Phone _____

Insurance Co. Address _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Chaska Dental Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

(Signature of Patient, Parent, Guardian, or Personal Representative)

_____

(Please Print Name of Patient, Parent, Guardian, or Personal Representative)