2849 County Highway I
Chippewa Falls, WI 54729

(715) 723-0287 7

Winn FAMILY DENTISTRY
A TRADITION OF EXCELLENCE

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Patient Information

Full Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Telephone Home: _____ **Telephone Work:** _____ **Mobile:** _____

Email Address: _____ **Gender:** _____ **Employer:** _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship:** _____

Guardian or Responsible Party (if different than above):

Full Name: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Telephone Home: _____ **Telephone Work:** _____ **Mobile:** _____

Insurance Policy (if applicable):

Name of Policy Holder: _____ **Date of Birth:** _____

SSN#: _____ **Employer:** _____ **Insurance Company:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Policy #(member ID) _____ **Group #:** _____ **Phone:** _____

Secondary Policy (if applicable):

Name of Policy Holder: _____ **Date of Birth:** _____

SSN#: _____ **Employer:** _____ **Insurance Company:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Policy #(member ID) _____ **Group #:** _____ **Phone:** _____

If you have more than 2 dental insurance policies, please notify our staff.

We are happy to assist you in understanding and filing your insurance for most dental procedures. Please remember your insurance is a contract between you, your employer, and your insurance company. Please understand that we can't speak on their behalf. We will gladly act as an advocate but can't be responsible for settling any disputed claims or coverage. We require payment of patient's estimated portion at the time of treatment. Our office policy states that you are solely responsible for your bill. If we don't receive payment from your insurance carrier within 60 days, we will notify you. Failure of your insurance carrier to reimburse our office within 60 days will result in our billing you directly for the remaining balance.

_____ _____ _____

Patient Name (Print) **Patient/Guardian Signature** **Date**