2849 County Highway I
Chippewa Falls, WI 54729

(715) 723-0287 7

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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**