CHANDLER
Family Dentistry

253 Main Street
Warsaw, Virginia 22572
804-333-0226 Office
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ChandlerDentistryWarsaw.com

*Asterick indicates required information.

NEW PATIENT REGISTRATION PACKET

*Date: / / _____

*Patient's Name: _____ Preferred Name: _____

*Date of Birth: _ _ /_ _ /_ _ _ _ Social Security Number: XXX-XX-_ _ _ _ and/or Driver's License Number: _____

*Mailing Address: _____

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

*Home Phone: _____ *Mobile Phone: _____

*Email: _____ Married: ☐ Unmarried: ☐

FOR MINOR PATIENTS

Parents' Names: _____

Home Phone (if different from above): _____ Mobile Phone: _____

How did you first learn about Chandler Family Dentistry? Check all that apply: Social Media: ☐ Print Ad: ☐
Website: ☐ Referral: ☐

When was your last dental appointment?: / /

Name of your former dentist/practice?: _____

May we contact your former dentist to request your records?: Yes: ☐ No: ☐

What are your dental concerns today?: _____

EMERGENCY CONTACTS

*Name: _____ Relationship to You: _____ *Phone: _____

*Name: _____ Relationship to You: _____ *Phone: _____

BILLING, CREDIT, AND INSURANCE INFORMATION

I AM covered by dental insurance: ☐ I am NOT covered by dental insurance: ☐

Who is financially responsible for this account?: Self: ☐ Person Listed Below: ☐

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _ _ /_ _ /_ _ _ _ Social Security Number: XXX-XX-_ _ _ _ and/or Driver's License Number: _____

Address (if different from patient's address): _____

City: _____ State: _____ Zip Code: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Phone: _____

Spouse's Employer: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Contract Number: _____ Group Number: _____ Subscriber ID Number: _____

Do you have any ADDITIONAL insurance coverage?: Yes: ☐ No: ☐ Insurance Company: _____

Please read the following Chandler Family Dentistry policy and acknowledge your acceptance by signing below. As your dental care provider, our relationship is with YOU and NOT your insurance carrier. We will file your claim with your insurance company as a courtesy to you. However, you are the sole responsible party for all charges incurred and must guarantee payment.

*Signature: _____ *Date: / /

CHANDLER FAMILY DENTISTRY POLICIES REGARDING FEES AND SERVICES, INSURANCE

As your dental care provider, Chandler Family Dentistry strives to provide the best possible care using state-of-the-art techniques in a welcoming and safe environment. We do our utmost to provide accurate cost estimates for dental procedures. Please do not hesitate to ask questions or discuss your concerns with our knowledgeable and helpful administrative staff.

FEES AND SERVICES

Our fee schedule reflects a combination of usual and customary fees and local fee surveys. It also factors in time spent, the complexity of the procedure, supplies used, and lab fees. At a minimum, fees are evaluated on an annual basis. Chandler Family Dentistry does not send monthly statements.

We expect payment in full for services when performed.

I, _____, have read and agree to the above policy. I assume full responsibility for all charges incurred. I understand and acknowledge that if my dental account becomes delinquent, I will be responsible for payments of all unpaid balances, including but not limited to, finance charges, returned check charges, collection fees, court costs, and attorney fees.

INSURANCE CLAIMS

There are almost as many insurance plans as hours in a year. Insurance reimbursement for dental procedures can be confusing. As a courtesy, we will file your insurance claims so you may receive all the benefits you are entitled to under your plan. However, it is prudent to be fully informed about the parameters of your coverage.

Employers often provide insurance. Discuss your coverage with your employer or seek guidance from a plan representative. Many employers offer multiple plans; benefits can change yearly, as do co-pays and deductibles. Unfortunately, insurance companies often bundle or deny services that they feel are unnecessary or should be categorized differently. The contract between the insurance company and your employer or your insurance company and you determines fee reimbursement.

ASSIGNMENTS OF BENEFITS

I, _____, authorize the release of any health information necessary for processing of insurance claims by Chandler Family Dentistry. I authorize payment of any insurance claims due to Chandler Family Dentistry to be paid directly to her. I authorize Chandler Family Dentistry's staff to affix my signature on any dental insurance forms for myself and my family for the next five years beginning as of this date. A copy of this authorization will be valid as the original.

*Patient's or Responsible Party's Signature: _____

*Date: ____ / ____ / _____

APPOINTMENT CANCELLATION POLICY

Chandler Family Dentistry strives to provide excellent dental care to every patient, and scheduling adequate time with each patient contributes to that high level of care. However, when a scheduled appointment is missed without proper notice, it creates a lost opportunity for the practice to treat another patient.

THE CHANDLER FAMILY DENTISTRY APPOINTMENT CANCELLATION POLICY:
We require that you give our office 48 hours' notice if you need to reschedule your appointment. That allows for us to schedule another patient in your slot.

A $75.00 "missed appointment" fee will be charged to your account if you do not contact our office 48 hours before your scheduled appointment. A "missed appointment" fee cannot be billed to your insurance company. Payment of this fee is your responsibility and must be received before future appointments are scheduled.

Please reach out to our staff if you have any questions regarding this policy. They will be happy to address your concerns. Chandler Family Dentistry values every patient, and we appreciate the confidence you place in us as your dental care provider.

I have read and understood the Chandler Family Dentistry Appointment Cancellation Policy, and I agree to be bound by its terms. I also agree that the practice may amend such terms at anytime.

*Signature: _____ *Date: / /

COMMUNICATION PREFERENCES CONSENT

With your consent, Chandler Family Dentistry will email and/or text you appointment reminders and dental care updates. Please note that text and email communications from Chandler Family Dentistry are NOT encrypted, and therefore, may be at risk, however minimally, to inappropriate access. We will never share your email address with third parties.

*Please indicate your communication preference(s): Text Me: ☐ Email Me: ☐ Text and Email Me: ☐ Phone Call Only: ☐

TEXT COMMUNICATIONS
I consent to receiving text communications from Chandler Family Dentistry.

Indicate your acceptance by signing (initials only): _____

Mobile Phone: _____

EMAIL COMMUNICATIONS
I consent to receiving email communications from Chandler Family Dentistry.

Indicate your acceptance by signing (initials only): _____

Email: _____

I understand that my communication instructions will remain in force until I update Chandler Family Dentistry in writing.

*Patient's Name (please print): _____

*Patient's Signature: _____ *Date: / /

Complete ONLY if Chandler Family Dentistry is filing insurance on your behalf.

HIPPA - AN ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I am aware of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191HIPAA Privacy Practices set forth by the government and followed by Chandler Family Dentistry.

I would like a copy of the HIPAA Privacy Practices: Yes: ☐ No: ☐

Patient's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Signature: _____ Date: / /

FOR OFFICE USE ONLY

Chandler Family Dentistry was unable to obtain a written acknowledgement of Receipt of Privacy Practices because:

An emergency existed and a signature was not possible to acquire at the time: ☐

The patient refused to sign: ☐

A copy was mailed with a request for a signature by return mail: ☐

Chandler Family Dentistry was unable to communicate with the patient for the following reason: _____

Other: _____

Prepared By: _____

Signature: _____ Date: / /