CHANHASSEN DENTAL
Bradley Lembke, DDS
Todd Weber, DDS

Welcome!

The following confidental information is important for the dentist to know in planning your dental care.
Please answer each question as completely as possible.
Thank You!

Patient Information :

Name:_____ Birth Date:_____ SS#_____

Marital Status: Single ___ Married___Separated___Divorced___Widowed___Minor___

Address:_____ City:_____St:_____ Zip:_____

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

E-Mail Address:_____Occupation:_____

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

Emergency Contact (Someone NOT living with you): _____Phone ( )_____

Insurance Information:

Primary Coverage

Policyholder:_____Birth Date:_____Employer:_____

Insurance Company: _____Group #_____ID#_____

Secondary Coverage

Policyholder:_____Birth Date:_____Employer:_____

Insurance Company: _____Group #_____ID#_____

Patient Authorization

Hippa ->>	I hereby authorize Chanhassen Dental to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-determination of treatment plan fees, claims processing, utilization review or financial audit.
Cancelation Policy- >>	I understand a fee may be charged to my account for not providing at least 24 hours notice prior to canceling or rescheduling an appointment.
Disclosure Consent ->>	I give my consent to Chanhassen Dental to discuss with my spouse, family members, or guardian information to facilitate my treatment and/or payment on my account.
Financial Policy ->>	I understand that I am responsible for all charges whether or not they are covered by insurance. A finance charge of 1.5% per month (18% per annum) will be added to accounts not paid when due. An account may be declared in default if not paid in full within 90 days. Upon default I agree to pay 25% collection surcharge calculated on all amounts then due when default is declared, and I also agree to pay court costs and reasonable attorney fees for recovery efforts.

☐ I have read the above Authorization, or had it explained to me, and I understand its contents

Patient Signature: _____ Date: _____

If not financially responsible and/or under the age of 18 yrs of age:

Guardian / Guarantor: Name:_____
(Please Print)

Guardian / Guarantor Signature: _____Date: _____