EXPERIENCE BIOLOGICAL DENTISTRY & ENERGY MEDICINE

SCOTT M. CHANDLER, DMD

Patient Name: _____ Preferred Name:_____
Birth Date: _____ Age: _____ SSN: _____ Sex: M☐F ☐
Marital Status: Married/Single/Widowed/Divorced/Child Email Address:_____
Mailing Address: _____
City: _____ State:_____ Zip Code:_____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

Spouse/Parent: _____ SSN: _____ Birth Date: _____
Employer: _____ Work Phone: _____

Emergency contact person:_____ Phone: _____
Address: _____ Relationship to Patient: _____

Whom may we thank for referring you? _____

Dental Insurance Information

Please remember that insurance is considered a method of reimbursing the patient fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. As a courtesy we extend to our patients we will file your insurance claims. However all charges are your responsibility from the date services are rendered.

Primary Insurance (Please give receptionist your card to copy)

Policy Holder: _____ Birth Date:_____
SSN: _____ Relationship to patient: _____
Employer: _____
Insurance Company Name: _____ Policy ID#:_____
Group#: _____ Phone number: _____
Claims Address: _____

Assignment of Insurance Benefits: I hereby authorize my insurance benefits to be paid directly to *Scott M Chandler, DMD*. I am responsible for all services not covered. I authorize the release of any dental information and/or x-rays necessary to process any claim.

****Signature*:_____ Date:_____
(Patient, legal guardian or authorized agent of Patient)

Submit