DeChellis DDS & Stonestreet

Thank you for choosing our dental team! We will strive to provide you with the best possible dental care. To help us meet your dental needs, please fill out these forms completely and thoroughly.

PATIENT INFORMATION:

Patient Name_____ _____
Social Security #_____ Birth Date_____ Male ☐ Female☐
Mailing
Address_____
Street City State Zip

☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Employer_____ Occupation_____
Whom may we thank for referring you?_____
How did you learn about our practice? (Circle all that apply) Friend/Family Work/School Dental/Medical Office Website Google Insurance Company

CONTACT INFORMATION:
Home Phone_____
Work Phone_____
Cell Phone_____

Email Address_____

Emergency Contact:
Name_____
Relationship_____
Phone Number _____

ACCOUNT INFORMATION: Person responsible for account:
Name_____
Relation_____
Billing Address _____
_____
Social Security #_____
Birth Date_____
Home Phone_____
Cell Phone_____
Work Phone_____
Email _____

INSURANCE INFORMATION:

(Please present card to front desk prior to seeing the doctor)

Do you have additional dental insurance? ☐es ☐o

Ins. Company Name_____
Phone #_____
Subscriber Name_____
Relation_____
SSN_____ Birth Date_____
Employer_____

If yes, complete the following:
Ins. Company Name_____
Phone #_____
Subscriber Name_____
Relation_____
SSN_____ Birth Date_____
Employer_____

X_____ Date _____
Signature of Patient, Parent, or Guardian

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***Payment is due in full at the time of service for patients without dental insurance. Patients with dental insurance are required to pay deductibles at the time of service and are responsible for the remaining balance once your insurance claim is received.

***Our office policy requires 24 hour notice for cancellations. If we do not receive 24 hour notice a minimum fee of $25 will be charged.

I have read the above conditions of treatment and agree to their content.

X_____ Date _____

Signature of Patient, Parent, or Guardian