CHESTER DENTAL ASSOCIATES
WELCOME

We are pleased to welcome you to our practice. Please take a moment to fill out this form as completely as you can. If you have any questions we'll be happy to help you. We look forward to working with you in maintaining your dental health.

Patient name:

Sex: M___ F___ Date of Birth: _____________ Marital status: _____

Occupation: _________________________________

To whom may we thank for referring you?

____

Assignment and Release:

I hereby authorize payment directly to Chester Dental Associates, for all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependants.**

I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party:

____ Date: ___________