BUCHANAN | CHUN ORTHODONTICS

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Orthodontic Specialists

Welcome! *We are pleased you have chosen our practice for your orthodontic needs. To help us serve you better, please take a few moments to fill out this form* ***completely prior*** *to your visit. If you have any questions, just ask - we will be glad to help. We look forward to working with you in achieving your goal…A great smile! Please visit our website @ www.mybraces.com and check out our facebook page for exciting news feed.*

Patient Information

Email Address _____

Date _____ Home phone _____

Name _____ Social Security # _____

Home Address (no P.O. Box) _____ Mailing Address _____

City _____ State _____ Zip code _____

Sex: ❑ Male ❑ Female Age _____ Birthdate _____ / _____ / _____ E-Mail _____

If Student: School _____ Grade _____ Full Time _____ Part Time _____

Hobbies, Interests, Active Sports _____

Has any mem–ber of your family been a patient in this office ❑ yes ❑ no If yes, Name _____

Sibling Info: Name _____ Male ❑ Female ❑ Birthdate _____

Sibling Info: Name _____ Male ❑ Female ❑ Birthdate _____

Whom may we thank for referring you? _____

Whom may we notify in case of an emergency? _____ Phone _____

Responsible Party

Who is financially responsible for this account? Email Address: _____

Name _____ DL# _____ State _____

Relation to patient _____ Birthdate ____ / ____ / ____ Social Security# _____

Address _____ Phone _____

City _____ State _____ Zip _____ ❑ **Rent** ❑ **Own**

Employed by _____ Occupation _____ # of Years Employed _____

Business address _____ Work phone _____

❑ Single ❑ Married ❑ Separated ❑ Divorced

If Separated or divorced, who has primary custodial care? _____

If divorced, whom does child live with? _____

Spouse's Name _____ Birthdate _____

Spouse's Address (If different): _____ Home Phone _____

Social Security# _____ Relationship to patient _____ Work Phone _____

Spouse's Employer _____ Occupation _____ # of years employed _____

Insurance

Please complete one for each insurance you have.

Insured's name _____

Relation to patient _____

Date of Birth _____

Address (if different from patient) _____

_____

City _____ State _____

Zip _____ Phone _____

Social Security# _____

Insurance Company _____

Member ID # _____ Group # _____
(Required for Coverage Verification)

Employer _____

Work Phone _____

If divorced, please complete for parent who has insurance.

Other insured's name _____

Relation to patient _____

Date of Birth _____

Address (if different from patient) _____

_____

City _____ State _____

Zip _____ Phone _____

Social Security# _____

Insurance Company _____

Member ID # _____ Group # _____
(Required for Coverage Verification)

Employer _____

Work Phone _____

Insurance Authorization

I have reviewed this patient information sheet and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the orthodontist to determine insurance plan benefits.

I authorize the dental staff to perform the necessary services my child may need. I also authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I authorize use of this signature on all insurance submissions.**

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MYSELF/DEPENDENTS.

Signature _____ Date _____

(For children under 18, parent or guardian must sign)

UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

I, _____ authorize Lani Chun, DDS to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Lani Chun, DDS. I authorize Lani Chun, DDS to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is Lani Chun, DDS's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____

Patient or Responsible Party Signature Date

Credit Authorization

I, _____, authorize Lani Chun, DDS to obtain my credit report information.
Print Name

Signature of responsible party _____

SIGNATURE WILL BE HELD ON FILE UNTIL FULL ORTHODONTIC SERVICES ARE PROVIDED. AT THAT TIME THE CREDIT REPORT WILL BE RUN.