

Jane J Chen DDS PC
4715 Statesmen Dr., Suite E
Indianapolis, IN 46250
Tel (317)578-9696 Fax (317)578-9797
Email: chenddspc@sbcglobal.net Website: www.chenddspc.com

Patient Name _____

Insurance Information

Do you have dental insurance? Yes No If yes, please complete the following:

Primary Insurance

Name of Insured _____ Relationship to patient _____
Birthdate _____ SSN _____ Date employed _____
Employer _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group number _____
Insurance company address _____ City _____ State _____ Zip _____

Do you have any additional insurance? Yes No If yes, complete the following:

Additional Insurance

Name of Insured _____ Relationship to patient _____
Birthdate _____ SSN _____ Date employed _____
Employer _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group number _____
Insurance company address _____ City _____ State _____ Zip _____

Communication

Please **check all** your preferred methods of communication.

- | | |
|---|---|
| <input type="checkbox"/> Home Phone _____ | <input type="checkbox"/> Work Phone _____ |
| <input type="checkbox"/> Mobile Phone _____ | <input type="checkbox"/> Email _____ |
| <input type="checkbox"/> Pager _____ | <input type="checkbox"/> Fax _____ |
| <input type="checkbox"/> U.S. Mail _____ | |
| <input type="checkbox"/> Others _____ | |

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I understand that Dr. Chen and staff will contact me to discuss clinical information related to my care. I agree that the staff and Dr. Chen may contact me at any of the

methods of communication indicated above. If I do not answer the phone, they may leave a message on my voice mail or answering machine. I agree that they may send a facsimile to the number or email me at the address I have listed above to convey information about appointments, lab test results, clarify medication dosages, or answer simple dental or insurance questions. Dr. Chen and staff will not address complex dental issues or make diagnoses by email.

- You may disclose information to my family members and/or non-family members.
Please list name, phone number, and relationship.

Name	Phone Number	Relationship

Signature _____ **Date** _____

Printed Name _____

Consent to Treat

The undersigned hereby authorizes Dr. Chen and staff to perform any diagnostic aids deemed necessary to make a thorough diagnosis of my needs. I also authorize Dr. Chen and staff to perform any and all forms of dental treatment and therapy that may be indicated.

Signature _____ **Date** _____

Printed Name _____