Kimberly Voges, D.D.S.

CHIP / Medicaid

Patient Information

Patient Name: ___________________________ Date of Birth: _____________ M / F

Address:__________________________ City: ______________ State: ___ Zip:________

Home Phone: ___________________ S.S.# ______________________

Responsible Party

Name: _______________________________ Date of Birth: ______________ M / F

Address:__________________________ City: _____________ State: ____ Zip:________

Home Phone: _____________________ Cell Phone: ____________________________

Email: ___________________________ D.L.#:_____________ S.S.# _______________

Employer: _________________________________ Work Phone: _________________

Employer's Address: ___________________________ City:______________ State: ____

Insurance

Check one:

- ❑ Delta CHIP
- ❑ Delta Medicaid
- ❑ MCNA CHIP
- ❑ MCNA Medicaid
- ❑ DentaQuest CHIP
- ❑ DentaQuest Medicaid

Policy #: ______________________ Group #: ___________________

I understand that the Children's Health Insurance Program (CHIP) provides benefits for preventive and therapeutic dental services based on qualifying tiers which limit the maximum amount of benefits that will be paid during each year of eligibility. _______ (initial)

I understand that not all services are covered by the CHIP / Medicaid plans and I assume financial responsibility for any and all services provided but not covered. _______ (initial)

I understand that I will be charged a minimum of $50 for failing to bring my child to a scheduled appointment or for failing to cancel a scheduled appointment with at least 24 hours notice. _______ (initial)

Signature of Parent/Guardian _____________________________ Date ______________

Printed Name of Parent/Guardian ____

Dr. Voges requires a consent form to be signed by a parent/guardian for every procedure.

PLEASE DO NOT DROP OFF OR LEAVE YOUR CHILDREN!