WELCOME

Tell Us About Your Child

Today's Date: ____________

Name: ____________
Last First M.I.

Birthdate: ____________ ___ Male ___ Female

Nickname: ____________

Home #: ____________

Address: ____________

____
City State Zip

School: ____________ Grade: ____________

Sports/Hobbies/Activities: ____________

____

General Information

Whom do we thank for referring you? ____________

Dentist: ____________ Date of Last Visit: ____________

Dentist Phone #: ____________

Physician: ____________ Date of Last Visit: ____________

Physician Phone #: ____________

He/She currently under the care of a doctor? Y N

Preferred Mail Method: *Circle* Email Regular Mail

Parent/Guardian Information

Who is *financially* responsible for the account: ____________

Parent's Marital Status: *Circle* Single Married Partnered Widow Divorced Separated

☐ Father ☐ Stepfather ☐ Guardian ☐ ____________

Name: ____________ Birthdate: ____________

Address: (If different from Child's)

____

City: ____________ State: ____________ Zip: ____________

Cell#: ____________ Wk#: ____________ Ext: ____________

Email: ____________ SSN: ____________

Employer: ____________

____
Employer Address City State Zip

Dental Insurance Co. Name: ____________

Circle Primary Policy Secondary Policy

Member ID # (or SSN if not applicable): ____________

____
Insurance Address City State Zip

Phone #: ____________ Group #: ____________

☐ Mother ☐ Stepmother ☐ Guardian ☐ ____________

Name: ____________ Birthdate: ____________

Address: (If different from Child's)

____

City: ____________ State: ____________ Zip: ____________

Cell#: ____________ Wk#: ____________ Ext: ____________

Email: ____________ SSN: ____________

Employer: ____________

____
Employer Address City State Zip

Dental Insurance Co. Name: ____________

Circle Primary Policy Secondary Policy

Member ID # (or SSN if not applicable): ____________

____
Insurance Address City State Zip

Phone #: ____________ Group #: ____________

Authorization

I understand that I am responsible for payment of services at the time they are rendered. Insurance claims will be submitted and payment from the insurance company will be sent to the insured. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I further authorize the use of this signature on all my insurance submissions and credit card payments, whether manual or electronic.

____
Signature of Parent/Guardian Date