PATIENT INFORMATION
CHILD

Child's Name Last ____________________ First ______________________ MI ________
Preferred Name ______________________ Birth Date ___________ SS # ______________

Father's Name ______________________________ Social Security # ______________
Mailing Address ____
Street Address __________________________ **Email address** ____________________
Phone Number (H) _______________ (W) _________________ (C) __________________
Is it O.K. to call you at Work? ____Yes ____No. Is it O.K. to call you on Cell? ____Yes _____No.
Date Of Birth ____________ Employer ____
Position _____________________________________ How Long ________________

Mother's Name ________________________ Birth Date ________ SS # ______________
Mailing Address ____
Street Address __________________________ **Email address** ____________________
Phone Number (H) _______________ (W) _________________ (C) __________________
Is it O.K. to call you at Work? ___Yes ____No. Is it O.K. to call you on Cell? ____Yes _____No
Employer _______________________ Position ______________ How Long ____________
Child Lives with? Mother_____ Father _____ Both _____ Grandparent _____

How did you hear about our office? (please be as specific as possible)

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Dental Insurance Information
Insurance Company ____
Insurance ID# ______________________________ Group#: ___________________________
Name of Insured: ____________________________ Relationship to Patient: _____________
Employer ___________________ Deductible? ________________ Annual Max. __________
Ins. Co. address ___________________________ City __________ State ________ Zip ______

Additional Dental Insurance Information
Do you have additional Insurance? ___Yes ____ No. If yes, complete the lines following:
Insurance Company: ____
Insurance ID#: ______________________________ Group#: ___________________________
Name of insured ______________________________ Relationship to patient ____________
Employer ___________________ Deductible? ________________ Annual Max. __________
Ins. Co. address ___________________________ City __________ State ________ Zip ______

Insurance Authorization, release, and Agreement to Pay For Services Rendered
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents:

____ ____________________
Signature of Patient or Parent if minor Date