PATIENT INFORMATION

❒ MALE ❒ FEMALE

CHILD'S FULL NAME _____ Preferred Name _____

DATE OF BIRTH _____ SS# _____ SCHOOL NAME _____

HOBBIES or INTERESTS or PETS _____

SIBLINGS' NAMES _____

RESPONSIBLE PARTY INFORMATION

□ Parent (Relationship_____) □ Legal Guardian

□ Parent (Relationship_____) □ Legal Guardian

Name _____

SS # _____ Date of Birth _____

Address _____

_____

City State ZIP

Email: _____

Ph H ( ) _____ Wk ( )_____

Cell ( ) _____

Occupation _____

Employer _____

Dental Insurance No Yes ❒ check here if Primary

Name _____

SS # _____ Date of Birth _____

❒ check here if the address & home ph # are the same

Address _____

_____

City State ZIP

Email: _____

Ph H ( ) _____ Wk ( )_____

Cell ( ) _____

Occupation _____

Employer _____

Dental Insurance No Yes ❒ check here if Primary

PRIMARY DENTAL INSURANCE _____ GROUP # _____ ID# _____

SECONDARY DENTAL INSURANCE _____ GROUP # _____ ID# _____

Special family considerations of which we should be aware: _____

How did you hear about our practice? _____

Does this person have a child in our practice? Y N

Emergency contact (other than parent): _____

Name Relationship to Child Phone #

I understand I am responsible for payment of dental services and the fees are due the day of service. I understand balances remaining 30 days from date of service will be assessed a finance charge (18% annually). I agree to pay all collection and legal costs should this account become default. I understand that dental insurance is a method of sharing the cost of dental services but the fee for services is ultimately my responsibility. Returned checks or charge backs incur a $30.00 fee. If a pattern of cancellation develops or I fail to show for an appointment, I understand my child will be referred to another office for care.

Signature _____ Date _____