Child Patient Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City/State: _____

Male Female Zip Code: _____

Soc. Sec #: _____-_____-_____ Home Phone: (_____) _____-_____

Parent/Guardian Email Address: _____

Fathers Name: _____ Date of Birth: _____/_____/_____

Employer:_____ Work Phone: ( ) _____-_____

Social Security #: _____-_____-_____ Cell Phone: ( ) _____-_____

Does ***father*** have dental insurance through ***his*** employer? Yes No
If yes, is child covered under ***father's*** insurance? Yes No

Name of insurance company: _____ Group #: _____

Father's Ins. ID #: _____ Child's Insurance ID # _____
(May not be same as SS#) (May not be same as SS#)

Mother's Name: _____ Date of Birth: _____/_____/_____

Employer:_____ Work Phone: ( ) _____-_____

Social Security #: _____-_____-_____ Cell Phone: ( ) _____-_____

Does ***mother*** have dental insurance through ***her*** employer? Yes No
If yes, is child covered under ***mother's*** insurance? Yes No

Name of insurance company: _____ Group #: _____

Mother's Ins. ID #: _____ Child's Insurance ID # _____
(May not be same as SS#) (May not be same as SS#)

Additional Information

Name of School : _____ City/State: _____

Who referred you to our office?_____

In case of emergency, contact:_____ (_____)_____-_____
Name Phone Number

Your signature authorizes the release of information to your insurance company and it authorizes the assignment of benefits. **Patients are responsible for all costs not covered by their insurance company.** There is a 2% monthly finance charge on overdue accounts. Fees for collection agency will be added to your account. Your signature also authorizes the use of your records and clinical photographs for scientific publication or teaching provided your name remains anonymous.

X_____ _____/_____/_____
Signature of Parent/Guardian Date

Updated: _____ _____ _____ _____
Date and Initials