

GENERAL INFORMATION

Father's Name _____ (First) _____ (MI) _____ (Last) _____ SS# _____ DOB _____

Street _____ PO Box _____

City _____ State _____ Zip _____

Home Phone# _____ Work# _____ Cell# _____

Mother's Name _____ (First) _____ (MI) _____ (Last) _____ SS# _____ DOB _____

Street _____ PO Box _____

City _____ State _____ Zip _____

Home Phone# _____ Work# _____ Cell# _____

Marital Status: Married Divorced Separated Single Widowed

With Whom Does the Child Live? _____

Who is the Custodial Parent? _____

Who is Responsible for This Account? _____

Driver's License #: Father _____ Mother _____ E-mail: _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address & Phone # _____

Insured's Name _____

Insured's DOB _____

Insured's Employer _____

Insurance Effective Date _____

Group, Plan, Local or Policy # _____

SS# _____

Occupation _____

Relationship to Patient _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address & Phone # _____

Insured's Name _____

Insured's DOB _____

Insured's Employer _____

Insurance Effective Date _____

Group, Plan, Local or Policy # _____

SS# _____

Occupation _____

Relationship to Patient _____

IN CASE OF EMERGENCY

Name, address and phone of relative not living with you _____

Name, address and phone of friend or neighbor _____

PLEASE SIGN AND RETURN TO THE RECEPTIONIST

I have read the office financial policy. I authorize the dentist to bill my dental insurance and release information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

LIST ALL CHILDREN BELOW

1. Name _____ Sex _____ Age _____ Birthdate _____

2. Name _____ Sex _____ Age _____ Birthdate _____

3. Name _____ Sex _____ Age _____ Birthdate _____

4. Name _____ Sex _____ Age _____ Birthdate _____

5. Name _____ Sex _____ Age _____ Birthdate _____

6. Name _____ Sex _____ Age _____ Birthdate _____