CHILD REGISTRATION / INSURANCE INFORMATION

So that we may provide you with the best possible care, please complete this entire form. ***PLEASE PRINT***

Child's Name _____ Date _____

Address _____ City _____ State ____ Zip _____

Phone _____ Social Security # _____ Sex: M F Age _____ Birthday ____/____/____

Parent Name _____ E-mail Address _____

Single Married Partnered Separated Divorced Widowed Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Business Address _____ City _____ State _____ Zip _____

Parent Name _____ E-mail Address _____

Single Married Partnered Separated Divorced Widowed Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Business Address _____ City _____ State _____ Zip _____

Who is responsible for this account? _____ Relationship to patient _____

Billing Address _____ Tel. _____

Who is responsible for making appointments? _____

PRIMARY INSURANCE

Insured's Name		Social Security #
Insurance Company		Ins. Co. Phone Number
Address		
City	State	Zip
Group Number	ID Number	Birthdate
Insured's Employer		

SECONDARY INSURANCE

Insured's Name		Social Security #
Insurance Company		Ins. Co. Phone Number
Address		
City	State	Zip
Group Number	ID Number	Birthdate
Insured's Employer		

In case of an emergency, who should be notified? _____ Tel. _____

Who is the child's general dentist? _____ Tel. _____

Pharmacy Name, Address & Phone _____

Who may we thank for referring you? _____

PAYMENT IS DUE AT TIME OF TREATMENT unless prior arrangements have been approved. The parent or guardian who accompanies the child is responsible for payment. I understand that the information I have given is correct to the best of my knowledge and shall be held in the strictest of confidence and that it is my responsibility to inform the office of any changes in my child's medical status.. I authorize the dental staff to perform the necessary services my child may need.

_____ _____

Signature of patient or parent/guardian of minor Date

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If you must change or cancel an appointment we require that you communicate directly with our staff and give two full working days notice, or a cancellation fee will be charged.

_____ _____

Signature of patient or parent/guardian of minor Date