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

Mother / Legal Guardian	Father / Legal Guardian
Name_____ SS#_____ Date of Birth_____ Address _____ _____ City State ZIP Email: _____ Home ( ) _____ Wk ( )_____ Cell ( ) _____ Occupation _____ Employer _____ 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: _____ Home ( ) _____ Wk ( )_____ Cell ( )_____ Occupation _____ Employer _____ 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 _____