



PATIENT INFORMATION

Patient's Last Name **First Name** **Home Telephone** **Birthdate**

Patient's Social Security # _____ (required for CHP+ , Delta Dental)

Nickname **Sex** **Mailing Address** **Town** **Zip**

Father's Name **Occupation/Employer**

Mother's Name **Occupation/Employer**

Name and Age of Siblings: _____

PARENTS' INFORMATION: Single Separated Married Divorced Widowed

Contact Email Address

Father's Work # **Father's Cell #** **Mother's Work #** **Mother's Cell #**

Child's Physician **Telephone**

How did you hear about us? _____

Were you referred? yes no Referred by: _____

Referred for: _____

FINANCIAL POLICY

Payment is due when services are rendered. We accept cash, personal checks, MasterCard, Visa and Care Credit. In the case of divorce or separation, the parent who is present at the office with the child will be deemed financially responsible.

APPOINTMENT POLICY

If you are unable to keep an appointment, we ask that you give our office at least 24 hours notice.

Missed appointment fees may be applicable.

INSURANCE INFORMATION

Your insurance policy is a contract between you, your employer and your insurance company. Therefore, you are responsible for understanding your coverage, benefits and yearly maximum. An authorization will be required to bill your dental insurance company. Please complete the following so that we will have this on file.

PRIMARY INSURANCE CARRIER

SUBSCRIBER _____
 SUBSCRIBER ID# _____
 SUBSCRIBER'S EMPLOYER _____
 INSURANCE CARRIER _____
 GROUP# _____
 CLAIMS ADDRESS _____
 CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE CARRIER

SUBSCRIBER _____
 SUBSCRIBER ID# _____
 SUBSCRIBER'S EMPLOYER _____
 INSURANCE CARRIER _____
 GROUP# _____
 CLAIMS ADDRESS _____
 CITY _____ STATE _____ ZIP _____

I authorize my insurance company(s) to pay benefits directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I am responsible for all co-payments, deductibles and rejected charges.

I have read the above information and understand my obligations.

X _____
 Signature of Policy holder Date

X _____
 Signature of Financially Responsible Party Date