

**Patient's Name**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Nick Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ Sex M F

Address \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact: (Please list contact other than parent/guardian)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Parent or Guardian Information**

**Parent 1** \_\_\_\_\_ / \_\_\_/ \_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Birth Date \_\_\_\_\_ Drive License # \_\_\_\_\_  
 Address  Same as Patient \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

**Parent 2** \_\_\_\_\_ / \_\_\_/ \_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Birth Date \_\_\_\_\_ Drive License # \_\_\_\_\_  
 Address  Same as Patient \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

**Patient's Insurance Information**

**Primary Insurance**

Insurance Company \_\_\_\_\_ Claim Address \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Subscriber \_\_\_\_\_ / \_\_\_/ \_\_\_  
 (Legal Name) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_

**Secondary Insurance**

Insurance Company \_\_\_\_\_ Claim Address \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Subscriber \_\_\_\_\_ / \_\_\_/ \_\_\_  
 (Legal Name) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_

Referred by: \_\_\_\_\_

I hereby authorize Pediatric Dental at Bridgeport to provide dental services to the above named patient and to use and release medical and dental information as required for treatment, payment, and health care operations. I also assign Pediatric Dental all payments to which I am entitled for dental procedures. I understand that I am financially responsible for all changes weather covered by insurance or not. I have received a copy of the current Privacy Notice and financial policy.

Parent/Guardian Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_