

**PLEASE COMPLETE  
BOTH SIDES IN INK!**

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Oral and Maxillofacial Surgery

**CHILD / DEPENDENT INFORMATION SHEET**

Date \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex M F S.S.# \_\_\_\_\_ Age \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Physician \_\_\_\_\_ General Dentist \_\_\_\_\_ Orthodontist or Specialist \_\_\_\_\_

**Father's Name** \_\_\_\_\_

**Mother's Name** \_\_\_\_\_

Home Address \_\_\_\_\_

Home Address \_\_\_\_\_

Street \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

S.S.# \_\_\_\_\_ Birthdate \_\_\_\_\_

S.S.# \_\_\_\_\_ Birthdate \_\_\_\_\_

Where Employed \_\_\_\_\_

Where Employed \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

**INSURANCE INFORMATION: Primary** (1st to be billed)

Employee Name \_\_\_\_\_

Employer \_\_\_\_\_

Employee Birthdate \_\_\_\_\_

Name of Insurance \_\_\_\_\_

Employee SS# \_\_\_\_\_

Address \_\_\_\_\_

Employee I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Dental  Medical  Both

**INSURANCE INFORMATION: Secondary** (2nd to be billed)

Employee Name \_\_\_\_\_

Employer \_\_\_\_\_

Employee Birthdate \_\_\_\_\_

Name of Insurance \_\_\_\_\_

Employee SS# \_\_\_\_\_

Address \_\_\_\_\_

Employee I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Dental  Medical  Both

**FINANCIAL POLICY:** Payment is due in full on the date of service. We accept cash, checks, VISA, MasterCard, and Discover/Novus and alternative financing through Carecredit, a healthcare credit card.

**INSURANCE POLICY:** We will submit insurance claims for you. An INITIAL payment is due on the date of service.

**FINANCE CHARGE:** After 60 days any balance unpaid by your insurance is considered past due and is due in full by you. A finance charge of 1 1/2% is added monthly to your past due account. This represents an annual percentage rate of 18%.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize payment directly to Palm & Panek DDS PC of any and all medical and or dental insurance payments. This assignment remains in effect until revoked by me in writing.

**RELEASE:** I authorize Palm & Panek DDS PC to release any information regarding my treatment to my insurance company, dentist, or primary care physician.

**We realize that many families are in a state of change. Divorced, separated, single parent and blended families are now common. In many of these families the question of who is responsible for the children's account is uncertain. The policy in our office is that the parent who requests treatment for the child is responsible for all fees incurred.**

**I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE.**

SIGNED \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent / Guardian Requesting Care