WELCOME

1. About Your Child

Today's Date:_____/_____/______ File #:_________

Child's Full Name:_______________________________

Child's Nickname:___________________ Boy / Girl

Child' Birthdate:_____/______/_______ Age:_____

Child's Home Phone#:(____)____________________

Child's SS #:_____________________________________

Child's Home Address:___________________________

City:__________________State_______Zip________

Referred By:_____________________________________

2. Child's Family Information

Who is accompanying this child today?

________________________________ ________________

Full name (if other than parent) Relation to child

Do you have Legal Custody of this Child? YES NO

Mother's Full Name:______________________________

Mother / Step Mother / Guardian

Home Address:(O check if same as Child's)_____________________

City__________________State______Zip__________

Home Phone #:(____)_________Cell #:(____)_________

____________________ ___/___/___ _______________

Mother's Social Security # Date of Birth Mothers Drivers Lic #

Employer:__________________ **Occupation**__________

____

Employer's Address City State Zip

Work Phone #: (_____)________________ Ext:_________

Father's Full Name:_______________________________

Father / Step Father / Guardian

Home Address: (O check if same as Child's)_______________

City:___________________State_______Zip__________

Home Phone#:(_____)_________Cell #: (_____)_________

___________________ ___/___/___ _______________

Father's Social Security # Date of Birth Father's Drivers Lic #

Employer:____________________ Occupation__________

____

Employer's Address City State Zip

Work Phone #: (______) _______________Ext:_________

3. Insurance Information

Primary Dental Insurance

Insured's Name:_____________________________________

Relation:_____________Date of Birth____/____/______

Insured's ID#/ SS #:__________________________________

Group #(Plan, Local, or Policy#):_________________

Insured's Employer:___________________________________

Insurance Company:___________________________________

Address:____

City:________________State_____________Zip________

Phone #: (______)_____________________________________

Secondary Dental Insurance

Insured's Name:_____________________________________

Relation:_______________Date of Birth___/___/_____

Insured's ID#/SS#:____________________________________

Group # (Plan, Local, or Policy#):_________________

Insured's Employer:___________________________________

Insurance Company:___________________________________

Address:____

City:_________________State:___________Zip_________

Phone #: (______)_____________________________________

4. Account Information

Person Ultimately Responsible for Account

Name:__________________________**Relation:**__________

Billing Address:____

City:__________________________**State:**_________**Zip:**________

SS#:____________________ **Date of Birth** ____/____/________

Work#(______**)**_______________**Driver Lic #:**___________________

Payment Method: _____ **Cash** _____ **Check** _____ **Credit Card**

Credit Card #_____________________________ **exp**_____/______

I hereby authorize assignment of my insurance rights & benefits directly to the provider for services. I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsibile for all charges. Our Policy requires payment for all services at the time of visit. If the Account is not paid within 90 days of date of service, you will be responsible for interest fees, billing charges, collection agency fees, & any other expenses incurred in collecting your account.

Signature_____________________________**Date**___________