
Child Patient Information

Patient's Name (CHILD) _____ Date of Birth _____ Age _____

Child's Address _____ City _____ Zip _____

Home Phone # _____ Male ___ Female _____

PARENT'S INFORMATION

Who is responsible for this bill?

(Full Name) _____ Relationship _____ Home Phone # _____

Address _____ City _____ Zip _____

Your Employer _____ Work # _____ Cell# _____

Parent's Soc. Sec. # _____ Parent's Birth Date _____

Spouse _____ Work _____

Family Physician _____ Telephone # _____

Former Dentist _____ Telephone # _____

Name, Address & Telephone # of nearest relative not living with you:

.....
Dental Insurance Information

Primary Insurance Co. Name _____ Grp # _____

Name of Insured _____ Relationship with pt. _____

Insured Date of Birth _____ Insured Soc.Sec. # _____

2ndary Insurance Co. Name _____ Grp # _____

2ndary Name of Insured _____

2ndary Insured Date of Birth _____ Soc. sec # _____

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filling a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature

Date