



Your Child/ Children

Name _____ Name _____
Name _____ Name _____

Father

Name _____
Address _____
Employer _____ Occupation _____
SS # _____ DL # _____ Date of Birth _____
Phone #'s: Home _____ Work _____ Cell _____
Are you the custodial parent? Yes _____ No _____

Mother

Name _____
Address _____
Employer _____ Occupation _____
SS # _____ DL # _____ Date of Birth _____
Phone #'s: Home _____ Work _____ Cell _____
Are you the custodial parent? Yes _____ No _____
Parent's Marital Status:
Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Who is responsible for making appointments? _____
Whom may we thank for referring you to us? _____
E-mail address: _____

Primary Dental Insurance

Insured's Name _____ Relationship to Patient _____
Date of Birth _____ SS# _____
Employer Address _____ Occupation _____
Insurance Company _____ Group # _____
Insurance Company Address _____

Additional Insurance

Insured's Name _____ Relationship to Patient _____
Date of Birth _____ SS# _____
Employer _____ Occupation _____
Insurance Company _____ Group # _____
Insurance Company Address _____

For your convenience, we offer the following methods of payment: cash, personal check, or credit card.
Payment is due in full at each appointment.

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to the third party payers and/or other health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Parent or Legal Guardian: _____ **Date:** _____