

DATE _____

PATIENT INFORMATION

CHILD'S NAME(S): _____ Date of Birth: _____
_____ Date of Birth: _____
_____ Date of Birth: _____

RESPONSIBLE PARTY INFORMATION

(Please circle one): MOTHER/FATHER/LEGAL GUARDIAN

MOTHER NAME _____
Last First Initial

Date of Birth _____ SS# _____

Street Address _____

City _____ State _____ Zip _____ Phone _____
(Home)

Best time to call _____ Phone _____
(Cell/Work)

FATHER NAME _____
Last First Initial

Date of birth _____ SS# _____

Street Address (if different from above) _____

City _____ State _____ Zip _____ Phone _____
(Home)

Best time to call _____ Phone _____
(Cell/Work)

FAMILY STATUS (CIRCLE ONE): MARRIED/ SINGLE / OTHER/ DIVORCED

Email _____ for confirming appointments

Would you be interested in receiving email reminders for upcoming or unscheduled appointments? YES NO

PRIMARY DENTAL INSURANCE INFORMATION

Name of Subscriber _____
Last First Initial

Subscriber's Birth Date _____ ID # _____

SS# _____ Group # _____

Employer _____

Employer Address _____

Employer Phone _____

Insurance Company Name _____

Insurance phone _____

Insurance Address _____

SECONDARY DENTAL INSURANCE INFORMATION
(If applicable)

Name of Subscriber _____
Last First Initial

Subscriber's Birth Date _____ ID # _____

SS# _____ Group # _____

Employer _____

Insurance Company Name _____

Insurance phone _____

Insurance Address _____

UNDERSTANDING YOUR DENTAL INSURANCE

Dental Insurance is designed to help pay part of the cost of dental treatment. Dental insurance is not designed to pay all of the cost of treatment; it is more like a benefit towards the total costs.

We do our best to retrieve your child's dental benefits prior to their scheduled appointments. The information that we receive is not a guarantee of payment from your insurance company. They will only consider payment when a claim is received. The benefit information that we receive from them is very basic, meaning that the information that we provide to you is *only an estimate* based on the information provided to us. Since there is no guarantee that we will receive full payment from your insurance company, it is best to understand that ultimately you are responsible for your child's bill.

We do our best to provide your insurance company with proper documentation so the claims will be processed accurately. If you do have a dispute regarding payment or non-payment from your insurance company, please call them, they can better help you understand their reasoning behind it.

Your insurance contract is between you and your insurance company. The type of benefits in your contract depend on what your employer has negotiated with that company and the amount of money you want to pay for the premium. Filing insurance claims is a service that we provide for you free of charge, but in no way relieves you responsibility for you bill.

Please refer to your benefit booklet for restrictions and exclusions on your policy.

REFERRAL SOURCE

Whom may we thank for referring you to our practice? (Please be specific) _____

RELEASE

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. Insurance estimates given are not a guarantee of payment from your insurance company. Any balance left unpaid by the insurance company is the responsibility of the patient’s guardian.

In consideration for the professional services rendered to me or my child by this practice, I agree to pay the charges for the services at the time of treatment.

I authorize my insurance company to directly pay the dental office.

I understand that by signing below that I am responsible for charges for all consented treatment.

I understand that by signing below I acknowledge my financial responsibility for my child’s dental services.

PRIVACY STATEMENT

I give permission to the doctor and staff to release health information to other health care professionals that are involved with the patient’s care., including my insurance company.

My signature below acknowledges that I have received the practice privacy statement.

Parent or Legal Guardian (responsible party) Date