Child Financial and Demographic Information

Child's Name _____ Date of Birth _____

Person financially responsible: _____ Relationship to child _____

☐ I am over 18 & under 21 and a dependent of my parents. I agree to the release of my records to my parents.

Home address _____ Mother's name _____

City _____ State ____ Zip _____ Mother's phone _____

Billing address _____ Father's name _____

City _____ State ____ Zip _____ Father's phone _____

Mother's email _____ Father's email _____

Child's physician _____ Phone number _____

Child's former dentist _____ Last visit _____

Emergency Contact _____ Phone _____

☐ Parent ☐ Relative ☐ Friend

Primary Dental Insurance

Name of Policy holder _____

Employer _____

Insur. company _____

Insur. Co. address _____

Policy holder's ID/Soc Sec # _____ Group # _____

Policy holder's birthdate _____

Secondary Dental Insurance

Name of Policy holder _____

Employer _____

Insur. company _____

Insur. Co. address _____

Policy holder's ID/Soc Sec # _____ Group # _____

Policy holder's birthdate _____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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 behalf of my child. I hereby grant permission to perform any necessary work for this child.

Date _____ Signature _____