

# 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 \_\_\_\_\_