REFERRED BY_____

PATIENT NAME_____

ADDRESS_____

HOME PHONE_____ CELL PHONE _____ AGE_____

DATE OF BIRTH_____SEX_____

FATHER'S NAME_____PHONE_____

EMPLOYED AT_____

FATHER'S ADDRESS_____

FATHER'S S.S. NUMBER_____FATHER'S BIRTHDAY_____

MOTHER'S NAME_____

EMPLOYED AT_____

MOTHER'S ADDRESS_____PHONE_____

MOTHER'S S.S. NUMBER_____MOTHER'S BIRTHDAY_____

EMERGENCY CONTACT_____PHONE_____

DENTAL INSURANCE COMPANY_____

POLICY OR I.D. NUMBER_____

SUBSCRIBER'S NAME_____

SECONDARY INSURANCE_____

SUBSCRIBER'S NAME_____

POLICY OR I.D NUMBER_____

PHYSICIAN'S NAME_____ PHONE_____

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES, SURGERIES, OR HEART PROBLEMS?

_____

ALLERGIES TO FOOD OR MEDICINE_____

CURRENT MEDICATIONS_____

THE POLICY IN OUR OFFICE IS THAT THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED.

SIGNATURE OF PARENT REQUESTING CARE

_____

I HEREBY CERTIFY THAT THE FOREGOING INFORMATIONS IS TRUE AND CORRECT.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE DIRECT PAYMENT TO DENTAL ASSOCIATES. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL UNPAID AMOUNTS.

SIGNATURE_____DATE_____

FOR FUTURE VISITS:

SIGNATURE_____DATE_____

SIGNATURE_____DATE_____

SIGNATURE_____DATE_____

SIGNATURE_____DATE_____