

YOUR CHILD'S INFORMATION

Date: _____

First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ Soc Sec: _____ Home Phone: _____ Sex: Male Female

Address: _____ City, State, Zip: _____

Parent or Guardian Information: Name _____ Mother Stepmother Guardian

Address: _____ City, State, Zip: _____

Phone#: _____ Employer: _____ SS# or Drivers Lic#: _____

Parent or Guardian Information: Name _____ Father Stepfather Guardian

Address: _____ City, State, Zip: _____

Phone#: _____ Employer: _____ SS# or Drivers Lic#: _____

Emergency Contact: _____ Phone#: _____

Whom may we thank for referring you: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Birth Date: _____ Insurance ID#: _____ Group Number: _____

Insurance Company: _____ Employer _____

Address: _____ City, State, Zip: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Birth Date: _____ Insurance ID#: _____ Group Number: _____

Insurance Company: _____ Employer _____

Address: _____ City, State, Zip: _____

AUTHORIZATION AND AGREEMENT WITH DENTISTS, INC.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize release of information to all my insurance companies. I understand that I am financially responsible to Dentists, Inc. for payment of all services rendered on my behalf, or on behalf of my child, children, or dependents whether or not paid by insurance.

I understand that payment is due in full at the time of treatment unless prior arrangements have been approved.

Signature of Parent or Guardian _____ Date _____