Pediatric Dental Associates, L.L.C

PATIENT INFORMATION

Child's Full Name _____ Nickname _____

Date of Birth _____ Age _____ Male / Female

School _____ Grade _____

Home Address _____

Home Phone _____ Sibling(s) names _____

How did you hear about us? Newspaper / Church Bulletin / Direct Mailer / Town Guide / Other _____

PARENT / GUARDIAN INFORMATION

Mother's
Full Name _____ Date of Birth _____

SS # _____ Cell phone _____ Work phone _____

Home address _____ Home phone _____

Email address _____

Father's
Full Name _____ Date of Birth _____

SS # _____ Cell phone _____ Work phone _____

Home address _____ Home phone _____

Email address _____

INSURANCE INFORMATION

Policy Holder's Full Name _____ Date of Birth _____

Employer _____

Insurance Company Name _____ Phone _____

Insurance Company Address _____

Subscriber # _____ Group # _____ Payor Id# _____

Financial Arrangement:
All payment arrangements must be in advance. In the case of default on payment, I agree to pay ALL collection costs and attorney fees. I authorize Pediatric Dental Associates, LLC to release any information to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to Pediatric Dental Associates, LLC. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature _____ Date _____