

## General Family Information

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent's or Guardian's Names \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

Dad's Work \_\_\_\_\_ Phone \_\_\_\_\_  
Work Address \_\_\_\_\_ Dad's SS # \_\_\_\_\_  
\_\_\_\_\_

Dental Insurance coverage Y or N (Circle one)

If yes, name of insurance carrier \_\_\_\_\_

Policy Number \_\_\_\_\_ Ins. Address \_\_\_\_\_  
\_\_\_\_\_

Insurance Phone Number \_\_\_\_\_

Mom's Work \_\_\_\_\_ Phone \_\_\_\_\_  
Work Address \_\_\_\_\_ Mom's SS # \_\_\_\_\_  
\_\_\_\_\_

Dental Insurance coverage Y or N (circle one)

If yes, name of insurance carrier \_\_\_\_\_

Policy Number \_\_\_\_\_ Ins. Address \_\_\_\_\_  
\_\_\_\_\_

Insurance Phone Number \_\_\_\_\_

If two insurance companies, which is primary \_\_\_\_\_

Parent's Marital Status: Married Separated Divorced (circle one)

Who does child live with? \_\_\_\_\_ Responsible Party \_\_\_\_\_

I authorize release of any information relating to this claim and payment directly to the dentist otherwise payable to me.

Date: \_\_\_\_\_ Signature of Parent: \_\_\_\_\_

Unless prior arrangements are made we request all balances be paid within 10 days of receipt of statement. If this is not possible, and we have not previously made other arrangements, please call us to do so. A thirty day old balance will have a 1.5 percent bookkeeping fee applied. This is an annual rate of 18%. We hope our policy is convenient for you, but if not, please feel free to discuss it with us. In the event of default, and my account is assigned to a collection agent, I agree to pay all costs of collection including reasonable attorney fees.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_