

Family Information

PATIENT'S FULL NAME			DATE OF BIRTH	
ADDRESS			CITY	ZIP CODE
			<input type="checkbox"/> M <input type="checkbox"/> F	
HOME PHONE () ()		CELL PHONE () ()		
FATHER'S FULL NAME	ADDRESS (IF DIFFERENT FROM PATIENT'S)		HOME PHONE () ()	CELL PHONE () ()
FATHER'S EMPLOYER	BUSINESS ADDRESS		FATHER'S WORK PHONE () ()	OCCUPATION
FATHER'S DATE OF BIRTH	FATHER'S SOCIAL SECURITY #	FATHER'S DRIVER'S LICENSE #	E-MAIL ADDRESS	
MOTHER'S FULL NAME	ADDRESS (IF DIFFERENT FROM PATIENT'S)		HOME PHONE () ()	CELL PHONE () ()
MOTHER'S EMPLOYER	BUSINESS ADDRESS		MOTHER'S WORK PHONE () ()	OCCUPATION
MOTHER'S DATE OF BIRTH	MOTHER'S SOCIAL SECURITY #	MOTHER'S DRIVER'S LICENSE #	E-MAIL ADDRESS	
NAME & PHONE OF CLOSE RELATIVE OR FRIEND			SIBLINGS NAME & AGE	
HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN THIS OFFICE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME				

Authorization & Financial Responsibility

IS YOUR CHILD COVERED BY A DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, UNDER WHOSE PLAN IS CHILD COVERED? <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> DUAL COVERAGE		EMPLOYERS NAME, (IF PLAN IS THROUGH YOUR EMPLOYER. IF NOT, PLEASE PUT "SELF"?)		
NAME OF PARENT INSURED (1)	NAME OF INSURANCE CARRIER	GROUP OR POLICY #	MEMBER ID #	
NAME OF PARENT INSURED (2)	NAME OF INSURANCE CARRIER	GROUP OR POLICY #	MEMBER ID #	
IS YOUR CHILD COVERED BY A DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, UNDER WHOSE PLAN IS CHILD COVERED? <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> DUAL COVERAGE		EMPLOYERS NAME, (IF PLAN IS THROUGH YOUR EMPLOYER. IF NOT, PLEASE PUT "SELF"?)		
NAME OF PARENT INSURED (1)	NAME OF INSURANCE CARRIER	GROUP OR POLICY #	MEMBER ID #	
NAME OF PARENT INSURED (2)	NAME OF INSURANCE CARRIER	GROUP OR POLICY #	MEMBER ID #	

I hereby authorize A Tooth Doctor For Kids and its associates to perform any and all treatment for my above named child and consent to such methods, drugs, and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled.

I understand that payment is expected for service rendered at the time of each visit and take financial responsibility of the patient named above. Financial arrangements may be made following the diagnosis. A monthly finance charge of 1 1/2% is added to all balances after 30 days (APR of 18%). For patients with dental insurance: On your behalf, our office will bill your insurance after treatment is complete. Often these payments are not received until 2-3 months after being submitted for payment. Please note you are responsible for the total charges until we receive payment from your carrier. Therefore, we ask that you pay your estimated share of your treatment as treatment is rendered.

SIGNATURE OF RESPONSIBLE PARTY (PARENT OR LEGAL GUARDIAN)	RELATIONSHIP TO PATIENT	DATE
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please complete the other side of this form