

Welcome to Children's Dental Health Associates PC

Thank You for Selecting US

YOUR CHILD

Child's Name: _____ Sex: M F Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Nickname: _____ Social Security#: _____ - _____ - _____ Birthdate: ____/____/____

School: _____ Grade: _____

Do you already have an appointment? Yes Date: _____ Time: _____ AM PM ; No Please Call To Arrange

PARENT OR GUARDIAN INFORMATION (MOTHER OR GUARDIAN)

Name: _____ Relationship: _____

Address: (if different than child's) _____

City: _____ State: _____ Zip: _____ Phone: _____

Social Security # _____ - _____ - _____ Birthdate: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone _____

PARENT OR GUARDIAN INFORMATION (FATHER OR GUARDIAN)

Name: _____ Relationship: _____

Address: (if different than child's) _____

City: _____ State: _____ Zip: _____ Phone: _____

Social Security # _____ - _____ - _____ Birthdate: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone _____

PRIMARY DENTAL INSURANCE

Insured's Name: _____ Relationship: _____

Social Security # _____ - _____ - _____ Birthdate: _____

Employer: _____

Insurance Company _____ Group# _____ ID# _____

Ins. Co. Address _____ City: _____ State: _____ Zip: _____

FINANCIAL ARRANGEMENTS

For your convenience we offer the following methods of payment. Please check the option you prefer. Payment in full is due at each appointment. Cash Personal Check Visa MasterCard

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Signature of Parent or Guardian _____ Date _____