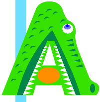
Welcome ...

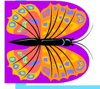
Tell Us About Your Child ...



Child's Name:______________________________ Nickname:______________ SS#______________
Last First MI

Address: ____ Birthdate:__________ Gender: • M • F
Street City State Zip

How did you hear about us?



I was referred by: • another dentist • physician • patient Name of Referral Source:__________________

I saw Dr. Brown's name on: • his sign • yellow pages • Other______________________________

Tell Us About Your Family...

Name of Person Bringing Child Today ______________________ Relationship to Child______________

Mother's Name: (or • Stepmother • Guardian)______________________ Marital Status:______________

Birth Date:______________ Social Security #:______________________ Employer______________________

Home Address:______________________________ E-Mail Address______________________________

Phone #'s: Home______________ Work____________ Ext__________ Cell______________ Other______________

Father's Name: (or • Stepfather • Guardian)______________________ Marital Status:______________

Birth Date:______________ Social Security #:______________________ Employer______________________

Home Address:______________________________ E-Mail Address______________________________

Phone #'s: Home______________ Work____________ Ext__________ Cell____________Other______________

Tell Us About Your Primary Dental Insurance...

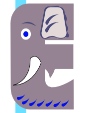
Insured Name:______________________________ Ins. Birthdate:____________ Ins. Wk Phone:______________
Last First MI

Insurance Co. Name:______________________________ ID#:____________________ Group #:______________

Insurance Co. Address:______________________________ Insurance Co. Phone #:______________________

Employer Name:__________________________ Employer Address:______________________________________

Tell Us About Your Secondary Dental Insurance...



Insured Name:______________________________ Ins. Birth Date:____________ Ins. Wk Phone:______________
Last First MI

Insurance Co. Name:______________________________ ID#:____________________ Group #:______________

Insurance Co. Address:______________________________ Insurance Co. Phone #:______________________

Employer Name:__________________________ Employer Address:______________________________________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. In consideration for the dental services rendered at my request I agree to pay the reasonable value of said services to said Doctor at the time said services are rendered.

As a condition of your treatment by this office, financial arrangement's must be made in advance. Financial responsibility for each patient must be determined before treatment. A service charge of 18% per annum (1½% per month) will be charged on any unpaid balance exceeding 30 days unless prior arrangements have been made.

Patients who carry dental insurance understand that all dental services provided are charged directly to the responsible party and that he or she is personally responsible for payment. This office will file insurance forms if adequate information is provided and all collections will be credited to the patients account. However the responsible party is responsible for all charges not paid by insurance.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I agree that I am responsible for paying costs related to collection of my account, should it become delinquent, to include attorney, collection and court costs.

I understand that my child's dental records are kept electronically and that I may receive a paper copy of these records at no charge during normal office hours.

____

Signature of Responsible Party Today's Date