Welcome To Our Practice!

PEDIATRIC DENTISTRY AND BEYOND

Please take a few moments to complete this form (front & back)

Today's Date _____ Child(ren)'s Name(s) _____

Birth date(s) _____ Age(s) _____Preferred Name (s): _____

☐ Male ☐ Female School(s) _____ Grade(s) _____

Do you have any other children that have been here before? ☐ Yes ☐ No Name (s)_____

Home Address _____
Street City State Zip

Primary Phone #_____☐ Cell ☐ Home Secondary Phone #_____☐ Cell ☐ Home

Who Is Accompanying The Child(ren) Today? Name_____ Relation_____

Emergency Contact (other than parents)

Name _____ Relation _____ Phone #_____

Whom may we thank for referring you to our practice?

Name of Person or Practice (s)_____ Address_____

Online Search Engine_____ Other_____

Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single ☐ Domestic Partners

Do you have legal custody of this child? ☐ Yes ☐ No Is the child adopted? ☐ Yes ☐ No Is the child in a foster home? ☐ Yes ☐ No

Parent 1: Check if applicable: ☐ Step Parent ☐ Guardian/Foster Parent Birth date _____Phone _____

Name _____ Social Security # _____

Address (if different from child) _____
Street City State Zip

Employer _____
Name Street City State Zip

Work Phone _____Occupation _____ E-Mail _____

Cell Phone _____ Drivers License Number _____ State of Issue_____
(needed for check writing purposes)

Parent 2: Check if applicable: ☐ Step Parent ☐ Guardian/Foster Parent Birth date _____Phone _____

Name _____ Social Security # _____

Address (if different from child) _____
Street City State Zip

Employer _____
Name Street City State Zip

Work Phone _____Occupation _____ E-Mail _____

Cell Phone _____ Drivers License Number _____ State of Issue_____
(needed for check writing purposes)

(Please complete both sides)

Primary Dental Insurance Information

Insurance Company _____

Is this a medical policy also? ☐ Yes ☐ No

Policy Owners Name:_____

ID #_____ Group #_____

Insurance Co. Phone # _____

Insurance Address_____

Relationship to Patient _____

Policy Owner's Birth date _____

SS# or ID#_____

Employer _____

Secondary Dental Insurance Information

Insurance Company _____

Is this a medical policy also? ☐ Yes ☐ No

Policy Owners Name:_____

ID #_____ Group #_____

Insurance Co. Phone #_____

Insurance Address_____

Relationship to Patient _____

Policy Owner's Birth date _____

SS# or ID#_____

Employer _____

All co-payments are due at time of service.
Insurance coverage is only estimation. The guarantor is responsible for all treatment not covered by insurance.
In the case of **divorced parents,** the parent **bringing** the child to the appointment is responsible to **us** for the account at time of service. We will not get involved in any personal disputes or arraignments, however; we are happy to provide a receipt at the end of the appointment so you can be reimbursed by the other party.

Dental History

Is the child currently in pain? ☐ Yes ☐ No What is the primary reason for today's visit? _____

Previous/Present Dentist _____ Last Visit _____
(Please Circle)

Is your child currently receiving dental treatment from any specialists? (Example: Orthodontic Treatment) ☐ Yes ☐ No

If yes, for what? _____

Who is providing this treatment? _____
Name Address Phone Number

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in that may occur. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co., and I assign directly to Dr. Demetriou and Dr. Singh all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent or guardian Date

Check Acceptance

We use a verification system to process check payments. In order for us to accept checks we must be provided with **one** of the following **for each parent writing checks to the office**:

(1) Social Security Number or (2) Drivers License Number **(please be sure to fill in information under parent information section if you will be writing checks to the office).**

Disclaimer: When you provide a check as payment, you authorize the use of your information for verification of check writing history. Acceptance of checks is not guaranteed. It will be dependent on the result of the check verification process.

Signature of parent or guardian Date