

Patient Number: \_\_\_\_\_

# Welcome To Pediatric Dental Care

Patient's Name: \_\_\_\_\_ , \_\_\_\_\_  
Last First Nick Name

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male/Female

Name of School / Day Care: \_\_\_\_\_ Grade/Level: \_\_\_\_\_

Other siblings in our practice: \_\_\_\_\_ Interests/Hobbies: \_\_\_\_\_

Reason For visit: \_\_\_\_\_

Referred By: \_\_\_\_\_

Please specify: Primary Dentist/ Pediatrician/Neighbor/Relatives/Existing patients/Yellow Book/  
Verizon Yellow Pages/Community Red Book/ Web site/Insurance/Other

How would you like to be contacted if necessary: Home Phone/ Cell Phone/ Work Phone/Email/Mail?

*(Please circle more than one option)*

Someone to notify in case of emergency: \_\_\_\_\_

*(Someone other than parents with current phone number please)*

Father's Name: \_\_\_\_\_ Mother's Name : \_\_\_\_\_

E-mail: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Mothers's Employer: \_\_\_\_\_

Present Position: \_\_\_\_\_ Present Position: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone/Pager: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Person who is responsible for the account: \_\_\_\_\_

*(Name))*

## DENTAL INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Group Plan: \_\_\_\_\_ Member Number: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_

Date of Birth for Subscriber: \_\_\_\_\_ SS# of Subscriber: \_\_\_\_\_

## AUTHORIZATIONS

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer. I also understand that if my account has to go to collections after 90 days due to non payment, late payment, returned checks or other reasons, applicable fees ( such as interest, and handling fees) would be added to the existing balance before submission to collections.

I attest to the accuracy of the information on this page.

Patient/Parent or guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CHILD REGISTRATION

You will receive a copy of Pediatric Dental Care Notice of Privacy act at our office upon your arrival. You may then sign below. Thank You.

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I have received a copy of **Notice of Privacy Practices** at **Pediatric Dental Care**.

\_\_\_\_\_  
Please Print Name of your child/minor

\_\_\_\_\_  
Please Print Your Name (Parent)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*Welcome Aboard*

***We hope we can make your child's dental visits the best and most  
pleasant dental experiences ever.***

***Please feel free to share your concerns with us at any time on the  
web: [info@thedentistforkids.com](mailto:info@thedentistforkids.com)***