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: ___________________________
E-mail: ___________________________
Home Address: ___________________________
City:______________State:_____ Zip:________
Home Phone: ___________________________
Father's Employer: ___________________________
Present Position: ___________________________
Work Phone: ___________________________
Cell Phone/Pager: ___________________________

Mother's Name :___________________________
E-mail: ___________________________
Home Address: ___________________________
City:______________State:_____ Zip:________
Home Phone: ___________________________
Mothers's Employer: ___________________________
Present Position: ___________________________
Work Phone: ___________________________
Cell Phone/Pager: ___________________________

Person who is responsible for the account: ____

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: _________________________

Father SS#: _______________________ Mother SS#: _______________________________

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 herby 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

Copyright (c) 2007 Pediatric Dental Care L.L.C . - All rights reserved.

ACKNOWLEGEMENT 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 ☺