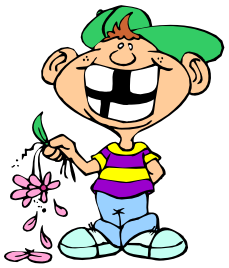
WELCOME



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a life time.

PATIENT INFORMATION

DATE_____

CHILD'S NAME_____
LAST FIRST MI

Preferred Name_____ BOY / GIRL AGE_____

CHILD'S BIRTHDATE_____

ADDRESS_____

_____
CITY STATE ZIP

CHILD'S SS #_____

MOTHER'S INFORMATION

NAME_____

ADDRESS_____

HOME #_____WORK #_____

CELL #_____

SS #_____

DATE OF BIRTH_____

EMPLOYER_____

FATHER'S INFORMATION

NAME_____

ADDRESS_____

HOME #_____WORK #_____

CELL #_____

SS #_____

DATE OF BIRTH_____

EMPLOYER_____

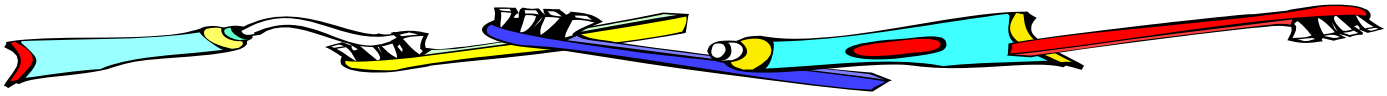
Parents Marital Status:

Married Divorced Separated Single

OTHER FAMILY MEMBERS WE SEE

_____

OVER



PERSON RESPONSIBLE FOR ACCOUNT

NAME_____

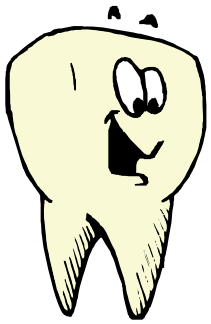
RELATIONSHIP TO PATIENT_____

BILLING ADDRESS_____

_____

HOME #_____WORK #_____CELL #_____

EMPLOYER_____



PRIMARY DENTAL INSURANCE

INSURANCE COMPANY NAME_____

INSURED'S NAME_____

ID #_____

EMPLOYER_____

RELATIONSHIP TO PATIENT_____

SECONDARY DENTAL INSURANCE

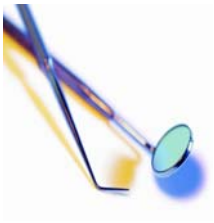
INSURANCE COMPANY NAME_____

INSURED'S NAME_____

ID #_____

EMPLOYER_____

RELATIONSHIP TO PATIENT_____



MEDICAL INSURANCE

INSURANCE COMPANY NAME_____

INSURED'S NAME_____

ID #_____

EMPLOYER_____

RELATIONSHIP TO PATIENT_____

Missed Appointments: Please realize we have reserved time especially for your child. If for some reason you must cancel your child's appointment we **expect 24 hours notice**. Our office has a voice mail system available at all times.

Late Appointments: We understand that your time is as valuable as ours, so we strive to make sure we are on time for your child's appointment. If you are late, it is possible that your appointment will be rescheduled.

Insurance: Please bring your **current** insurance card the day of your appointment. We will submit your insurance claim for you. **Please be prepared to pay the deductible and co-payment the day of service**.

The parent or guardian who accompanies the child is **responsible for payment** at the **time of service**, unless prior arrangements have been approved. **We accept cash, check, Visa or Mastercard** and if a **payment option** is needed please ask us about **CareCredit**.

_____

Signature Relationship to patient Date

Office Use

____Dental History ____Hipaa Info ____Medical History ____Medical Consent ____Insurance Information ____Financial Policy