PATIENT INFORMATION - Minor

DATE ______________________

NAME ______________________ ❒ MALE ❒ FEMALE
LAST FIRST M

SS# ______________________ BIRTH DATE ______________________
MONTH DAY YEAR

MINOR RESIDES WITH ❒ MOTHER ❒ FATHER ❒ BOTH PARENTS ❒ OTHER

FATHER ______________________ SS# ______________________
LAST FIRST M

ADDRESS ______________________
STREET APT. # CITY STATE ZIP

Telephone ______ / ______ / ______ / ______
HOME WORK CELL FAX

PLACE OF EMPLOYMENT ______________________

MOTHER ______________________ SS# ______________________
LAST FIRST M

ADDRESS ______________________
STREET APT. # CITY STATE ZIP

Telephone ______ / ______ / ______ / ______
HOME WORK CELL FAX

PLACE OF EMPLOYMENT ______________________

OTHER ______________________ Relationship to Minor ______________ SS# ______________
LAST FIRST M

ADDRESS ______________________
STREET APT. # CITY STATE ZIP

Telephone ______ / ______ / ______ / ______
HOME WORK CELL FAX

PLACE OF EMPLOYMENT ______________________

DENTAL INSURANCE INFORMATION

* DO NOT LIST MEDICAL INSURANCE

PRIMARY INSURED	SECONDARY INSURED
Subscriber ______________________ LAST FIRST M	Subscriber ______________________ LAST FIRST M
Relationship ❒ SELF ❒ SPOUSE ❒ OTHER __________	Relationship ❒ SELF ❒ SPOUSE ❒ OTHER __________
SUBSCRIBER ID# GROUP #	SUBSCRIBER ID# GROUP #
NAME OF GROUP	NAME OF GROUP
NAME OF INSURANCE COMPANY	NAME OF INSURANCE COMPANY
CLAIMS ADDRESS & TELEPHONE	CLAIMS ADDRESS & TELEPHONE

ALTERNATE CONTACT

*** OUTSIDE OF FAMILY HOUSEHOLD**

Name ______________________ Relationship ______________

Address ______________________

City/State/ZIP ______________________

Telephone # (Hm) ______________ (Wk) ______________

(Cell) ______________

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X ______________________
Patient or Responsible Party

____
Date State Driver's License #

Whom may we thank for referring you to our office?

____

METHOD OF PAYMENT

*** INSURED PATIENTS PAY DEDUCTIBLE AND CO-PAYS**

❒ Payment in full at each appointment (cash or check)

❒ Payment in full at each appointment (Visa, MC, Discover)

Card # ______________________ Exp. Date __________

I, ______________________ authorize automatic charge to the above listed account of any dental expenses due.

❒ Office Payment Plan
You must be approved prior to dental care. Please ask receptionist for application.

SERVICE CHARGE
Any account balance over 90 days is subject to an annual percentage rate of 12%.