Patient Update

Date:_____

Tell Us About Your Child

Child's Name _____
Last First Mi

Nickname_____

Siblings that we treat

Cellular Phone # _____

Child's Home # _____

Child's Home Address: _____
APT. / CONDO #

_____
City State Zip

Who does child live with? Mother Father

Email:_____
(Email is used for appt. reminders)

Who is Accompanying the Child Today?

Name _____

Relationship_____

Do you have legal custody of this child? Yes No

The parent or Guardian who accompanies the Child is Responsible for payment at the time of service.

Please Note: The parent who's Birthday falls first in the year (month) is primary, unless there is a divorce decree or legal document.

Please discuss any serious medical problems the child has had:

Please list all drugs the child is currently taking:

Please list all drugs/foods the child is allergic to:

Person Responsible for Account

Name _____

Relationship _____

Billing Address

_____
City State Zip

Home # _____

Work # _____

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address

Insurance Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____

Social Security # _____

Policy Owner's Employer_____

Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address

Insurance Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____

Social Security # _____

Policy Owner's Employer_____

PARENT ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that the information provided on this form is accurate and that the person who brings this child to Dentistry for Children is the legal guardian of this child. Whoever accompanies this child on subsequent visits has my express permission to consent to treatment. If this child should come for a subsequent visit unaccompanied, I hereby consent to treatment. I acknowledge that as the legal guardian, I am responsible for full payment of all charges including a broken appointment charge of $40 when appointments are missed without notice. I hereby authorize my insurance benefits to be paid to the undersigned dentist. I understand that any balance not paid within 60 days - regardless of outstanding insurance - incurs a finance charge of 1.5% per month (18% annually). If my account is referred to a collection agency or law firm to collect the unpaid balance, I understand and agree that I will be responsible for paying all collections costs, including but not limited to, reasonable attorney fees and court costs. I have received a copy of Dentistry for Children's Notice of Privacy Practices.

As an insurance cardholder, it is important that you as the patient are aware of your insurance benefits. Our office recommends that you confirm your insurance coverage prior to your appointment. This will help eliminate any insurance concerns once treatment has begun. **PLEASE UNDERSTAND** that we file dental insurance as a courtesy to our patients.
By my eSignature verification below, I verify that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures. Pursuant to section 11.100 of Title 21 of the Code of Federal Regulations, this is to certify that to confirm that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

_____ _____
Signature of Parent/Legal Guardian Date Relationship to Patient

_____
Printed Name of Parent/Legal Guardian