

• **Personal Information** • For age 16 and under

Name: _____ Date of birth: _____ Age: _____
Home address: _____
Home phone: _____ School: _____
Father's name: _____ Date of birth: _____
Employer: _____ Work phone: _____
Employer's address: _____
Mother's name: _____ Date of birth: _____
Employer: _____ Work phone: _____
Employer's address: _____
Person financially responsible: _____ D.L. # _____
Relationship to child: _____ Home phone: _____
Former dentist: _____ Date of last visit: _____
Whom may we thank for your referral?: _____

• **Insurance Information** •

Primary insurance company: _____ Name of policy holder: _____
Policy holder's social security #: _____ Policy holder's date of birth: _____
Employer: _____ Group #: _____
Secondary insurance company: _____ Name of policy holder: _____
Policy holder social security: _____ Policy holder's date of birth: _____
Employer: _____ Group #: _____

We will be happy to prepare the necessary forms to help you obtain your benefits from your insurance company. We do not, however, render our services on the basis that insurance companies will pay all of our fees. Each fee is individual for the individual patient. You, the patient, are fully responsible for any amount not covered by insurance or prepayment program. We allow thirty (30) days from the date of services to receive your insurance payment. There will be 1% monthly interest charged for accounts ninety (90) days past due. Please be aware that any insurance follow-up is the patient's responsibility.

Signature: _____ Date: _____