CHILD INFORMATION UPDATE

CHILD'S NAME: _____

Contact Cell Phone: _____ Contact Home Phone: _____

Contact Email: _____

1. HAS THERE BEEN A CHANGE IN YOUR ADDRESS, PHONE OR OTHER PERSONAL INFORMATION? YES NO

Child's Home Address_____

Father's Name _____ Home Address (if different) _____

Mother's Name _____ Home Address (if different) _____

2. IS YOUR CHILD RECEIVING MEDICAL TREATMENT OR CURRENTLY TAKING MEDICATION? YES NO

Child's Physician_____ MD Phone _____

Date of Last Exam _____

Reason for Exam _____

Please list all medications currently being taken: _____

_____

3. HAS YOUR CHILD BEEN HOSPITALIZED RECENTLY? YES NO

Dates of Hospitalization _____

Reason for Hospital Admittance _____

4. WOULD YOU LIKE US TO CREATE AN INSURANCE CLAIM FOR YOU? YES NO

Ins. Co. Name _____

Address _____

Ins. Phone # _____ Group # _____Plan #_____

Employer _____

Subscriber Name _____ Birthdate _____

Subscriber SSN _____ Relationship to Patient _____

INSURANCE RELEASE & FINANCIAL RESPONSIBILITY

I hereby authorize the release of any information, including but not limited to the records of any examinations, treatment and diagnosis to my insurance company or companies. This release is for the purpose of facilitating payment of my insurance benefits directly to our office for dental treatment.

Our office will assist with insurance billing, however treatment is not rendered on the assumption that charges will be paid by insurance. All dental treatment fees are the direct responsibility of the parent or guardian presenting the child for treatment. There will be a 1% service charge (12% annually) added to any unpaid balance over 30 days. Collection referral and clerical service fees are added to any unpaid balance after 60 days. Our NSF check and services fees are each $45.00.

I understand I am responsible for an accurate medical history and that all medical information is important in arriving at a diagnosis and treatment plan. I understand it is imperative to report any changes in my child's health or medication to their dentist.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____