CHILDREN'S CORNER PEDIATRIC DENTISTRY

NEW FAMILY INFORMATION
(Please Print)

YOUR CHILDREN'S INFORMATION:

***First Name:** ____________ Last Name: ____________ Date of Birth: ________ Sex: **M** **F**

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RESPONSIBLE PARTY:

First Name: ____________ Last Name: ____________ Date of Birth: ________ Relationship to patient: ________

Mailing Address: ______________________________
CITY STATE ZIP

Street Address (if different): ______________________________
CITY STATE ZIP

I agree that the dental practice may communicate with me electronically at the email address & mobile numbers below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I can withdraw my consent to electronic communications at anytime

Primary e-mail address: ____________ Secondary e-mail address: ____________

Home Phone: ____________ Work Phone: ____________ Mobile Phone: ____________

Employer: ____________ Occupation: ____________ Social Security #: ____________

Marital Status: Single Married Divorced Separated Widowed Patients mother/father (other than responsible party): ____________

Emergency Contact: ____________ Phone: ____________

Who referred your family? Dentist: ____________ Orthodontist: ____________ Physician: ____________

○ Friend ____________ ○ Phone Book ○ Insurance Company ○ Web

INSURANCE (PLEASE PRESENT MEDICAL/DENTAL CARDS FOR PHOTOCOPY):

PRIMARY COMPANY:

Insurance Name: ____________

Insurance Address: ____________

ID #: ____________ Group#: ____________

Policyholder: ____________

Address: ____________

Insurance Phone: ____________ Date of Birth: ____________

○ Medical ○ Dental ○ Auto Other: ____________

SECONDARY COMPANY:

Insurance Name: ____________

Insurance Address: ____________

ID #: ____________ Group#: ____________

Policyholder: ____________

Address: ____________

Insurance Phone: ____________ Date of Birth: ____________

○ Medical ○ Dental ○ Auto Other: ____________

CERTIFICATION OF INFORMATION:

We make every effort to keep the cost of your surgical care down. Payment arrangements can be made with our Financial Coordinator depending upon special circumstances. An ***estimate*** of the charge for any procedure or surgery you may require will be given to you. If you have medical and/or dental insurance, we will be glad to file a claim on your behalf. Please complete the insurance section above.

Please remember that insurance is considered a method of assisting in the cost of care and is not a guarantee of payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance and any other balance not paid by your insurance company. Past due balances are subject to a monthly finance charge.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the provider named on the insurance benefits form unless otherwise stated payable to me.

We guarantee the work performed by our Dentists provided the patient is seen by our Dentists every 6 months for their routine exam and cleaning.

Signature: ______________________________ Date: ____________

Acknowledgement of Receipt of Notice of Privacy Practices and Your Rights to Access Your Patient Files
Health Insurance Portability and Accountability Act (HIPPA)

I acknowledge that I have been offered a copy of the above Notice of Privacy Practices and Your Rights to Access Your Patient Files, to read. I understand that I may request a copy to keep for my files. My signature also gives my written consent to Children's Corner Pediatric Dentistry to use and disclose my health care information as set forth in this notice, except as I give specific written notice of restriction. *You may refuse to sign this acknowledgement*

Signature: ______________________________ Date: ____________