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PEDIATRIC DENTISTRY

NEW PATIENT INFORMATION

Patient Name_____
Nickname_____
Male_____ Female_____
DOB_____Age_____
School_____Grade_____
Siblings_____

Who may we thank for referring you?_____

Person accompanying patient to appointment_____
Relationship to patient_____
Do you have legal custody of the child?_____

Mother's Name: Ms. / Mrs. / Dr. (circle one)_____
Address_____
_____
Phone: Home_____Cell_____
Work_____Ext_____
Email_____
Occupation_____
Employer_____

Father's Name: Mr. / Dr. (circle one)_____
Address (if different from above)_____
_____
Phone: Home_____Cell_____
Work_____Ext_____
Email_____
Occupation_____
Employer_____

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INSURANCE AND ACCOUNT INFORMATION

Primary Insurance_____
Policy #_____Group #_____
Address_____
Phone_____
Policy Holder Name_____
Policy Holder DOB_____
Policy Holder SSN_____
Policy Holder Relation to Patient_____

Secondary Insurance_____
Policy #_____Group #_____
Address_____
Phone_____
Policy Holder Name_____
Policy Holder DOB_____
Policy Holder SSN_____
Policy Holder Relation to Patient_____

Person responsible for account_____
Relationship to patient_____
Address (if different from above)_____
_____
Phone (if different from above)_____

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Notice of Privacy Acknowledgement

Effective Date: April 24, 2003

I understand that, under the health insurance portability and accountability of 1996 (HIPPA) I have certain rights to privacy regarding my health information. I understand this information can and will be used to:

*conduct and direct my treatment among the mutual healthcare providers
*obtain payment and billing for reimbursement for services and confirm coverage
*conduct normal health care operations
*I have received and read your notice of privacy practices. I have been given the opportunity to ask questions I may have regarding this notice

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Patient/Guardian Signature

Authorizations

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Patient/Guardian Signature

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

Patient/Guardian Signature