PATIENT INFORMATION

Name: _____ _____ _____ _____ M F
(last) (first) (middle init) (preferred name) (sex)

Complete Street Address: _____

City, State, Zip Code: _____

Home Phone: _____ Birthdate: _____

Father's Name: _____ Mother's Name: _____

Father's Address (if different from patient's): _____

Mother's Address (if different from patient's): _____

Patient's Physician, Clinic and Phone: _____

Other children in the family (please list names and birthdates): _____

_____

How did you learn of our dental office? _____

RESPONSIBLE PARTY INFORMATION

Dr. Mr. Mrs. Ms. (circle one)

Name: (last) _____ (first) _____ (middle) _____

Complete Street Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship to Patient: _____

Employer: _____

Spouse's Name: (last) _____ (first) _____ (middle) _____

Spouse's Employer: _____

E-mail Address: _____

(PLEASE COMPLETE OTHER SIDE)

DENTAL INSURANCE INFORMATION

Policyholder's Name: _____ Relationship to Patient: _____

Social Security # or ID#: _____ Birthdate: _____

Insurance Company: _____ Group No.: _____

Insurance Company Address: _____

Employer: _____

DO YOU HAVE SECONDARY DENTAL COVERAGE? No [ ] Yes [ ] If yes, please complete the following

Policyholder's Name: _____ Relationship to Patient: _____

Social Security # or ID#: _____ Birthdate: _____

Insurance Company: _____ Group No.: _____

Insurance Company Address: _____

Employer: _____

Are you covered under Medical Assistance? Yes [ ] No [ ] ID No: _____

PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS.

IF YOU HAVE INSURANCE – Insurance is a contract between the policyholder and the insurance company. Please remember that insurance is meant as an aid, not a pay all. As a courtesy to you, we will submit your insurance claims on your behalf and will do all we can to help you receive the full benefits of your policy. We can make to guarantee of estimated coverage for payment. In the event your insurance company fails to respond or denies payment, the amount owed is your responsibility.

I certify the above information is true and correct, and I agree to full financial responsibility of all charges for treatment rendered, regardless of insurance involvement.

Signature (parent's signature if a minor): _____ Date: _____

EMERGENCY INFORMATION

Name of nearest relative or contact person not living with you: _____

Phone Number: _____

I have received a copy and read Duluth Pediatric Dentistry's payment policy and cancellation policy.

Signature (parent's signature if a minor): _____ Date: _____