PATIENT UPDATE

PEDIATRIC SPECIALISTS
Dentistry FOR CHILDREN
DRS. DILL, VARBLE, WONG & PARKS

TELL US ABOUT YOUR CHILD

CHILD'S LEGAL NAME:

_____
LAST FIRST MI

PREFERRED NAME: _____ ❑ MALE ❑ FEMALE ❑ OTHER

SIBLINGS THAT WE TREAT: _____

CHILD'S BIRTHDATE: _____

BEST CONTACT # _____

ADDITIONAL # _____

CHILD'S HOME ADDRESS: _____

_____

WHO DOES THE CHILD LIVE WITH? _____

EMAIL: _____
EMAIL IS USED FOR APPOINTMENT REMINDERS

WHO IS ACCOMPANYING THE CHILD TODAY?

NAME: _____

RELATIONSHIP: _____

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ❑ YES ❑ NO

The parent or guardian who accompanies the child is deemed responsible for payment at the time of service, regardless of who provides insurance.
Please note: The parent whose birthday falls first in the year (month) is primary, unless there is a divorce decree or legal document.

PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THE CHILD HAS HAD:

_____

PLEASE LIST ALL MEDICATIONS THE CHILD IS CURRENTLY TAKING:

_____

_____

PLEASE LIST ANY FOOD / DRUG ALLERGIES:

_____

_____

RESPONSIBLE PARTY

NAME: _____

RELATIONSHIP: _____

BILLING ADDRESS: _____

_____

WORK # _____ CELL # _____

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE # _____

GROUP # (PLAN, LOCAL, OR POLICY #) _____

MEMBER ID # _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY OWNER'S BIRTHDATE: _____ SS# _____

POLICY OWNER'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE # _____

GROUP # (PLAN, LOCAL, OR POLICY #) _____

MEMBER ID # _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY OWNER'S BIRTHDATE: _____ SS# _____

POLICY OWNER'S EMPLOYER: _____

PARENT ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that the information provided on this form is accurate and that the person who brings this child to Dentistry for Children is the legal guardian of this child. Whoever accompanies this child on subsequent visits has my express permission to consent to treatment. If this child should come for a subsequent visit unaccompanied, I hereby consent to treatment. I acknowledge that as the legal guardian, I am responsible for full payment of all charges including a broken appointment charge of $40 when appointments are missed without 24 hours notice. I hereby authorize my insurance benefits to be paid to the undersigned dentist. I understand that any balance not paid within 60 days (regardless of outstanding insurance) will become my responsibility. If my account is referred to a collection agency or law firm to collect the unpaid balance, I understand and agree that I will be responsible for paying all collections costs, including but not limited to reasonable attorney fees and court costs. I have received a copy of Dentistry for Children's Notice of Privacy Practices.

As an insurance cardholder, it is important that you as the patient are aware of your insurance benefits. Our office recommends that you confirm your insurance coverage prior to your appointment. This will help eliminate any insurance concerns once treatment has begun. **PLEASE UNDERSTAND** that we file dental insurance as a courtesy to our patients.

By my eSignature verification below, I verify that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures. Pursuant to section 11.100 of Title 21 of the Code of Federal Regulations, this is to certify that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

_____ _____
SIGNATURE OF PARENT / LEGAL GUARDIAN RELATIONSHIP TO PATIENT

_____ _____
PRINTED NAME OF PARENT / LEGAL GUARDIAN DATE