

# **Smith Pediatric Dentistry, P.C.**

Child's Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex \_\_\_\_\_ M \_\_\_\_\_ F  
Child's Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_  
Who was your child's previous dentist? \_\_\_\_\_ When was their last cleaning and exam? \_\_\_\_\_

## **Responsible Party Information**

Legal Guardian/Parent of a minor child is responsible for account.

Parent's marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

### **Mother's Information:**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

### **Father's Information:**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

## **Insurance Information:**

### **Primary Insured Information:**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Group/Plan Number \_\_\_\_\_  
Dental Ins. Co. \_\_\_\_\_ Phone Number \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insured S.S. # \_\_\_\_\_

### **Secondary Insured Information:**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Group/Plan Number \_\_\_\_\_  
Dental Ins. Co. \_\_\_\_\_ Phone Number \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insured S.S. # \_\_\_\_\_

## **Person to contact in case of emergency:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## **Authorization:**

I hereby authorize payment directly to Smith Pediatric Dentistry, P.C. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Smith Pediatric Dentistry, P.C. to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or other health professionals. I also understand that credit bureau reports may be obtained if necessary. In the event the payment in full for charges incurred is not made I agree to pay all cost of collection, including a 50% collection fee, attorney fees, court costs & interest at the rate of 1.5% per month (18% per year).

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date