Davies
Pediatric Dentistry

CHILD'S INFORMATION			
Last Name:	First:	MI:	DOB:
Last Name:	First:	MI:	DOB:
Last Name:	First:	MI:	DOB:
Last Name:	First:	MI:	DOB:
Last Name:	First:	MI:	DOB:

PARENT INFORMATION	
Parent/Guardian 1	Parent/Guardian 2
Name:	Name:
Date of Birth:	Date of Birth:
Relationship to patient:	Relationship to patient:
Marital Status: □ Single □ Married □ Divorced □ Domestic Partnership □ Widowed	Marital Status: □ Single □ Married □ Divorced □ Domestic Partnership □ Widowed
Address ___ City ___ State___ Zip ___ □ Check if this is patient's primary address	Address ___ City ___ State___ Zip ___ □ Check if this is patient's primary address
Phone ( ) - □ Home □ Cell □ Work	Phone ( ) - □ Home □ Cell □ Work
Email:	Email:

INSURANCE INFORMATION	
Primary Coverage	Secondary Coverage
Subscriber Name:	Subscriber Name:
Social Security Number:	Social Security Number:
Employer:	Employer:
Insurance Company:	Insurance Company:
Subscriber/Member ID:	Subscriber/Member ID:
Group Number:	Group Number:
Insurance Company Phone # ( ) -	Insurance Company Phone # ( ) -

Our office will file a claim with your insurance company when possible. However, insurance policies and contracts differ considerably in the benefits offered. It is impossible for us to know the details involved in all the various policies. Dental insurance programs are designed to cover a portion of dental costs, and not the entire charges incurred. The responsible party who attended the appointment will be responsible for all charges, regardless of insurance coverage.

I authorize the release of information necessary to process my insurance claim, or to communicate with other doctors who may be involved in the patient's health care.

I authorize payment of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original. I understand I am responsible for any amount not covered by insurance.

Signature ________________________________ Date ________________