Date___________________________________

Name__________________________________

Date of Birth___________________________

Home address___________________________

____

City State Zip

Parent_________________________________

Home#_________________________________

List any medications your child is allergic to:

____

____

____

Insured Parent__________________________

List any medical problems:

____

____

____

List any medications your child is taking:

____

____

____

Does your child have any of the following habits ?

Y N Thumb/Finger sucking

Y N Nail biting

Y N Nursing Bottle Habits

Is your child on fluoridated water ?

Is this your child's first visit ?

INSURANCE RESPONSIBILITY: DENTAL INSURANCE_____________________________

Your dental insurance is based upon a contract between you and/or your employer and an insurance company. If you have questions about your benefits, it is best for you to contact your employer or insurance company directly. Regardless of any dental insurance benefits, the patient(responsible party) is ultimately responsible for all charges. Our office will submit most insurance claims; however, to keep our fees as low as possible, your "ESTIMATED" portion is expected on the date of service.

SIGNATURE_________________________________ DATE______________________________

FINANCIAL RESPONSIBILITY :

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my or my child's medical status. I also understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 60 days past due, delinquency at the lesser of the annual rate of 18%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

SIGNATURE_________________________________ DATE______________________________