



Welcome!

<p>ABOUT YOUR CHILD</p> <p>Today's Date: _____ / _____ / _____</p> <p>Child's Name: _____ <small style="margin-left: 20px;">Last</small> <small style="margin-left: 100px;">First</small> <small style="margin-left: 100px;">MI</small></p> <p>Child's Nickname: _____</p> <p style="text-align: center;">€ Boy Girl</p> <p>Child's Birth date: _____ / _____ / _____ Age: _____</p> <p>Child's Address: _____ <small style="margin-left: 20px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip</small></p> <p>Child's Home Phone#: (____) _____</p> <p>Child's SS#: _____</p> <p>School: _____ Grade: _____</p> <p>Referred By: _____</p> <p>Doctor's Name: _____</p> <p>Doctor's Address: _____</p> <p>Doctor's Phone #: (____) _____</p> <p>Kaiser Medical Record # _____</p>	<p>ACCOUNT INFORMATION</p> <p>Person ultimately responsible for account</p> <p>Name: _____</p> <p>Relation: _____</p> <p>Billing Address: _____ <small style="margin-left: 20px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip</small></p> <p>SS#: _____ D.O.B. _____ / _____ / _____</p> <p>Driver's License #: _____</p> <p>Cell Phone #: (____) _____</p> <p>Work Phone #: (____) _____</p> <p>Payment Method: CASH FINANCE _____ / _____</p> <p>CREDIT CARD - Enter Card # above (if accepted)</p> <p>initials _____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.</p>
<p>INSURANCE INFORMATION</p> <p><i>Primary Dental Insurance</i></p> <p>Co. Name: _____</p> <p>Address: _____ <small style="margin-left: 20px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip</small></p> <p>Phone#: (____) _____</p> <p>Insured's ID#: _____</p> <p>Group# (Plan, Local, or Policy #): _____</p> <p>Insured's Name: _____</p> <p>Relation: _____ Date of Birth: _____ / _____ / _____</p> <p>Insured's Employer: _____</p> <p><i>Secondary Dental Insurance</i></p> <p>Co. Name: _____</p> <p>Address: _____ <small style="margin-left: 20px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip</small></p> <p>Phone#: (____) _____</p> <p>Insured's ID#: _____</p> <p>Group# (Plan, Local, or Policy #): _____</p> <p>Insured's Name: _____</p> <p>Relation: _____ Date of Birth: _____ / _____ / _____</p> <p>Insured's Employer: _____</p>	<p>CHILD'S FAMILY INFORMATION</p> <p>Who is accompanying this child today? _____</p> <p>Full name if other than parent _____</p> <p>Relation to child Do you have legal custody of this child? yes no</p> <p>Mother's Name: _____ <small style="margin-left: 20px;">step mother</small> <small style="margin-left: 100px;">guardian</small></p> <p>(check if same as child's) HOME ADDRESS City State Zip (____) _____ (____) _____ Home Phone# Work or Cell Phone # _____ / _____ / _____</p> <p>Mom's SS# Date of Birth Mom's Drivers Lic. # _____ Employer: _____ How Long? _____</p> <p>Employer's Address City State Zip</p> <p>Father's Name: _____ <small style="margin-left: 20px;">step father</small> <small style="margin-left: 100px;">guardian</small></p> <p>(check if same as child's) HOME ADDRESS City State Zip (____) _____ (____) _____ Home Phone# Work or Cell Phone # _____ / _____ / _____</p> <p>Dad's SS# Date of Birth Dad's Drivers Lic. # Employer: _____ How Long? _____</p> <p>Employer's Address City State Zip</p>