Child Name_____

Address_____City/State/Zip_____

Home Phone_____Emergency Phone_____

School Name_____Full Time Student (Please Circle) Yes No

Date of Birth_____Sex (please Circle) Male Female

Primary Insured Name_____Relationship to Patient_____

Date of Birth_____Social Security #_____

Employer_____Occupation/Rank_____

Insurance Co. Name_____Plan or Group Number_____

Secondary Insurance Information (if applicable)

Name_____Relationship to Patient_____

Date of Birth_____Social Security#_____

Employer_____Occupation_____

Insurance Co. Name_____Plan or Group Number_____

Note: Make sure to read Carefully.

Before treatment can be rendered, adequate digital radiographs of the teeth must be taken. We will provide the best explanation to the parent or guardian of treatment to be rendered before treatment is started, so that they are aware of what procedures are going to be completed. I also understand that we do not medicate or restrain any child therefore if your child becomes a behavior management problem, he or she will be referred out to a pedodontist in order to receive the best possible care.

We do require 24 hours notice if you are unable to keep an appointment. You will be given one occurrence before you're charged a missed appointment fee of $25.00. if there is a third occurrence you will be asked to seek services elsewhere.

Unless otherwise arranged with a written financial agreement, payment for professional service is required on the day the treatment is rendered.

I consent to performance of any and all procedures on my child, and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures and all costs incurred in the collection of those fees, including billing charges, 18% interest on overdue accounts and all attorney fees.

The above information is accurate and all terms are acceptable to me.

Signed_____Date_____