

# WELCOME

## *Please Tell us About Your Child(ren)*

Today's Date \_\_\_\_\_

Child(ren)'s Name(s) \_\_\_\_\_ Birth date(s) \_\_\_\_\_ Age(s) \_\_\_\_\_

Nickname(s) \_\_\_\_\_  Male  Female School(s) \_\_\_\_\_ Grade(s) \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Child(ren)'s Home Phone ( ) \_\_\_\_\_

## *Who Is Accompanying The Child(ren) Today?*

Name \_\_\_\_\_ Relation \_\_\_\_\_

Do you have legal custody of this child?  Yes  No Is the child adopted?  Yes  No  
Is the child in a foster home?  Yes  No

Whom may we thank for referring you? \_\_\_\_\_  
Name Address

Other siblings seen by us: \_\_\_\_\_

## *Neighbor or Relative NOT Living With You – For Emergency Contact Only*

His/Her Name \_\_\_\_\_ Relation \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

## *Parent's Information*

Parent's Marital Status:  Married  Divorced  Separated  Widowed  Remarried  Single  Domestic Partners

**Mother:**  Step Mother  Guardian Birth date \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from child) \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_  
Name Street City State Zip

Work Phone ( ) \_\_\_\_\_ Occupation \_\_\_\_\_ E-Mail \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Drivers License Number \_\_\_\_\_ State of Issue \_\_\_\_\_  
(needed for check writing purposes)

**Father:**  Step Father  Guardian Birth date \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from child) \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_  
Name Street City State Zip

Work Phone ( ) \_\_\_\_\_ Occupation \_\_\_\_\_ E-Mail \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Drivers License Number \_\_\_\_\_ State of Issue \_\_\_\_\_  
(needed for check writing purposes)

***(Please complete both sides)***

**Dental Insurance Information – Primary**

Insurance Company \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
P. O. Box/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Owner's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policy Owner's Birth date \_\_\_\_\_ SS# or ID# \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Dental Insurance Information – Secondary**

Insurance Company \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
P. O. Box/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Owner's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policy Owner's Birth date \_\_\_\_\_ SS# or ID# \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Dental History**

Is the child currently in pain?  Yes  No What is the primary reason for today's visit? \_\_\_\_\_  
Previous/Present Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_  
(Please Circle)  
Is your child currently receiving dental treatment from any specialists? (Example: Orthodontic Treatment)  Yes  No  
If yes, for what? \_\_\_\_\_  
Who is providing this treatment? \_\_\_\_\_  
Name Address Phone Number

**Authorizations**

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in that may occur. I authorize the dental staff to perform the necessary dental services my child may need.

\_\_\_\_\_  
Signature of parent or guardian Date

I certify that my child is covered by \_\_\_\_\_ Insurance Co., and I assign directly to Dr. Demetriou all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

\_\_\_\_\_  
Signature of parent or guardian Date

**Check Acceptance (TeleCheck)**

We use the TeleCheck system to process check payments. In order for us to accept checks we must be provided with **one** of the following **for each parent writing checks to the office**:

(1) Social Security Number or (2) Drivers License Number **(please be sure to fill in information under parent information section if you will be writing checks to the office).**

TeleCheck Disclaimer: When you provide a check as payment, you authorize the use information from your check to process a one-time Electronic Funds Transfer (EFT) or draft drawn from your account, or to process the payment as a check transaction. You also authorize TeleCheck to process credit adjustments, if applicable. If your payment is returned unpaid, you authorize TeleCheck to collect your payment and the Return Fee amount (\$25) by EFT(s) or draft(s) from your account.

\*Signature will be kept on file for all TeleCheck authorizations

\_\_\_\_\_  
Signature of parent or guardian Date