

WELCOME

Please Tell us About Your Child

Today's Date _____

Child's Name _____ Birth date _____ Age _____

Nickname _____ Male Female School _____ Grade _____

Child's Home Address _____
Street City State Zip

Child's Home Phone () _____

Who Is Accompanying The Child 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 _____
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 _____
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 _____