

Smith and Macdonald Pediatric Dentistry, LLC

Child's Name _____ Today's Date _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Sex _____ M _____ F _____
Child's Date of Birth _____ Age _____ Grade _____ School _____
Who was your child's previous dentist? _____ When was their last cleaning and exam? _____

Responsible Party Information

Legal Guardian/Parent of a minor child is responsible for account.

Parent's marital status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Mother's Information:

Name _____ Home Phone _____
Address _____ Work Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Employer _____ Occupation _____
Date of Birth _____ SS# _____

Father's Information:

Name _____ Home Phone _____
Address _____ Work Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Employer _____ Occupation _____
Date of Birth _____ SS# _____

Insurance Information:

Primary Insured Information:

Name _____ Relationship to Patient _____
Employer _____ Group/Plan Number _____
Dental Ins. Co. _____ Phone Number _____
Insurance Co. Address _____
Insured S.S. # _____

Secondary Insured Information:

Name _____ Relationship to Patient _____
Employer _____ Group/Plan Number _____
Dental Ins. Co. _____ Phone Number _____
Insurance Co. Address _____
Insured S.S. # _____

Person to contact in case of emergency:

Name _____ Relationship _____ Phone _____
Whom may we thank for referring you? _____

Authorization:

I hereby authorize payment directly to Smith and Macdonald Pediatric Dentistry, LLC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Smith and Macdonald Pediatric Dentistry, LLC to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or other health professionals. I also understand that credit bureau reports may be obtained if necessary. In the event that payment in full for charges incurred is not made, I agree to pay all cost of collection, including a 40% collection fee, attorney fees, court costs & interest at the rate of 1.5% per month (18% per year). In the event of a returned check, I agree to pay a returned check fee of \$25.00. Payment is expected the date of service. If you have Insurance we will gladly process your claim, but require that you pay your estimated portion, co-payment or deductible at the time of dental visit.

Signature of Responsible Party

Date