Grace
Family Dentistry

1 About Your Child

Today's Date: ___/___/___ Patient DOB: ___/___/___

Patient Name: _____ Boy Girl

Nickname: _____ Age: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____

Child's SSN: _____

Name of Parent/Guardian: _____

Referred by: _____

2 Insurance Info

Primary Dental Insurance

Insured's Name: _____

Relation to Patient: _____

Insured's Employer: _____

Insured's ID#: _____

Group Number: _____

Ins Co. Name: _____

Phone: _____

Secondary Dental Insurance

Insured's Name: _____

Relation to Patient: _____

Insured's Employer: _____

Insured's ID#: _____

Group Number: _____

Ins Co. Name: _____

Phone: _____

3 Account Info

Person responsible for account

Name: _____

Relation: _____

Billing Address: _____

City: _____ State: _____

Phone: _____ home/work/cell

SS Number: _____

Payment Method

Payment is due at the time services are rendered.

_____ 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 carrier.

4 Family Info

Mother's Name: _____
Step Mother Guardian

Home Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____

Employer: _____ Work Ph: _____

Mother's SSN: _____ Birth Date: _____

Father's Name: _____
Step Father Guardian

Home Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____

Employer: _____ Work Ph: _____

Father's SSN: _____ Birth Date: _____

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