



Welcome to

# Dentist

Sonia Gutierrez, D.D.S., M.S. & Associates

## Tell Us About Your Child

Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Male/Female: \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Nickname: \_\_\_\_\_ School Name: \_\_\_\_\_

Current Age: \_\_\_\_\_ Current Grade: \_\_\_\_\_ Pets & Pets' Names: \_\_\_\_\_

Last Dental Visit: \_\_\_/\_\_\_/\_\_\_ Special Interests: \_\_\_\_\_

**\* Whom may we thank for referring you to our office?:** \_\_\_\_\_

(\*We use this information in our Referral Program. You can earn a \$25.00 Gift Certificate for Target. Ask our staff for details.)

## Responsible Party Information

**Name of Mother/Guardian:** \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Name of Father/Guardian:** \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

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## Insurance Information

As a courtesy our office can submit insurance claims on your behalf. Please fill this consent form completely.

- We do NOT have dental insurance.
- We have dental insurance.
- We have dual insurance.

Insured's Name: \_\_\_\_\_ Insured's birthdate: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone :(\_\_\_\_) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_\_  
Work Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Position: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Ins Co Phone:(\_\_\_\_) \_\_\_\_\_  
Ins Co Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group or Plan #: \_\_\_\_\_ ID #: \_\_\_\_\_  
Union Name: \_\_\_\_\_ Local #: \_\_\_\_\_

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the dentists and staff of Kids Dentist and will keep them informed if changes occur in my child's health or our other information. I authorize Kids Dentist to submit insurance claims on my behalf, if applicable, and assume financial responsibility for all fees, as the insurance plan is a contract between myself and my insurance carrier (not the dentist and the Ins Co).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### For Office Use Only:

Date Verified: \_\_\_\_\_  
Ins Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Eff Date: \_\_\_\_\_ Calendar Yr?: Y/N \_\_\_\_\_  
Deductible:\$\_\_\_\_\_/\_\_\_\_\_(Individual/Family) Preventive: \_\_\_\_\_% Ded Applies? Y / N Basic: \_\_\_\_\_% Major: \_\_\_\_\_%  
Yrly Max: \_\_\_\_\_ Cleaning Sched: \_\_\_\_\_ FL: \_\_\_\_\_ Sealants: \_\_\_\_\_  
Pano/Full mouth: \_\_\_\_\_ BWs: \_\_\_\_\_ Sp Maint: \_\_\_\_\_ SSC's: \_\_\_\_\_ Pulpals: \_\_\_\_\_ Nitrous: Y / N \_\_\_\_\_%  
Ortho: \_\_\_\_\_% Ded \_\_\_\_\_ Age Limit \_\_\_\_\_ Pymt Method \_\_\_\_\_ LT Max: \_\_\_\_\_  
Dental Accident? Y / N \_\_\_\_\_ Verified Address?: Y / N \_\_\_\_\_

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