KIDS Dentist

Practice Limited to Pediatric Dentistry

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?:**_____

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:_____

Over →

Primary / Secondary (Circle One)

Insurance Information

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

☐ I do NOT have dental insurance.

☐ We have dual insurance.

Insured's Name:_____ 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 #:_____

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: **Reference #:**_____

Date Verified:_____

Ins Contact:_____ Phone:_____ Eff Date:_____ Calendar Yr?: Y/N_____

Deductible:$_____/_____(Individual/Family) Preventive:_____% Ded Applies? Y / N Basic:_____% Major:_____%

Yrly Max:_____ Ded applies to: Pano? Y / N _____PA's? Y / N_____BWX? Y / N_____Seals? Y / N_____

Cleaning Sched:_____FL:_____ Pano/FMX:_____Min Age_____ BWs:_____

Sealants:_____%Freq_____1st/2nd_____Age_____ Sp Maint:_____ SSC's:_____ Pulps:_____ Nitrous: Y / N____%

HX-DOS: Pano_____Bwx_____OE,PRO,FL_____Seals_____

Does Preventive Apply To Yrly Max? Y / N_____

Posterior Downgrade for Composite fillings?: Yes or No

If Secondary Insurance: Standard COB or Non Duplication of Benefits (Circle One)