RESPONSIBLE PARTY INFORMATION

Patient Name: _____
First **Middle** **Last**

MOTHER / LEGAL GUARDIAN (Please circle) Name_____
Last First Middle

Address _____
Street/PO Box City State Zip

Date of Birth _____/_____/_____ Social Security # _____/_____/_____

Driver's License # _____ State _____ E-mail Address _____

Phone Numbers- Home_____ Cell_____ Work_____

Place of Employment _____Occupation_____

Name of Spouse (if different than Father/Legal Guardian)_____

FATHER / LEGAL GUARDIAN (Please circle) Name_____
Last First Middle

Address_____
Street/PO Box City State Zip

Date of Birth _____/_____/_____ Social Security # _____/_____/_____ Driver's License # _____ State _____

E-mail Address_____

Phone Numbers- Home_____ Cell_____ Work_____

Place of Employment _____Occupation_____

Name of Spouse (if different than Mother/Legal Guardian) _____

INSURANCE INFORMATION

If covered by traditional dental insurance please complete the following:

Insured's Name _____
Last First Middle

Social Security/ID#_____ Date of Birth_____/_____/_____Relationship to Patient _____

Insurance Company_____ Phone #_____ Employer_____ Group #_____

Insured's Name _____
Last First Middle

Social Security/ID# _____ Date of Birth _____/_____/_____ Relationship to Patient_____

Insurance Company_____ Phone #_____ Employer_____Group #_____

Please initial below:

_____ By signing this form, I agree to take full financial responsibility for this child's account independent of what a divorce decree may state. If dental insurance is applicable, I understand that my estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is payable upon receipt of statement. I understand that a FINANCE CHARGE with an Annual Percentage Rate of 18% will be imposed on any account balance 60 days or more outstanding.

_____ **I hereby authorize payment of dental insurance benefits, if any, to be made directly to Pediatric Dental Specialists, P.A.**

Signature of person completing form _____Date _____

Printed name_____Relationship to Patient _____