PEDIATRIC DENTAL ASSOCIATES

General Parent Information

The child lives with ( ) both parents ( ) parent 1 ( ) Parent 2 ( ) Other

PARENT/GUARDIAN 1
( ) Father
( ) Mother
( ) Other
_____

NAME_____
SSN_____ DOB_____
STREET_____
CITY_____STATE_____ZIP_____
Home Phone:_____CELL:_____
Occupation:_____
Employer:_____
Business Address:_____
Business Phone:_____

PARENT/GUARDIAN 2
( ) Father
( ) Mother
( ) Other
_____

NAME_____
SSN_____ DOB_____
STREET_____
CITY_____STATE_____ZIP_____
Home Phone:_____CELL:_____
Occupation:_____
Employer:_____
Business Address:_____
Business Phone:_____

DENTAL INSURANCE INFORMATION

Primary Insurance _____
Employer_____Employee_____
Group Number_____Subscriber Number_____
Secondary Insurance_____
Group Number_____Subscriber Number_____

MEDICAL INSURANCE INFORMATION
Insurance Company_____
Employer_____Employee_____
Group Number_____Subscriber Number_____

IN ORDER TO COMPLY WITH MOST INSURANCE COMPANIES, WE ASK THAT YOU SIGN BELOW SO THAT WE MAY KEEP YOUR SIGNATURE ON FILE. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC DENTAL ASSOCIATES.

Signature_____Date_____