PATIENT ACQUAINTANCE INFORMATION

Patient's Name _____ Phone No. _____

Patient's Date of Birth _____ Patient's Social Securtiy # _____

Patient's Address _____
Street # City, State Zip Code

Other Children in the family: (Are any of them patients of this practice ☐ Yes ☐ No)

Name _____ Age_____ Birthday _____

_____ Age_____ Birthday _____

Patient's Pediatrician _____ Pediatrician's Phone Number_____

Parent's Dentist _____

Is Patient covered by dental insurance? ☐ **No** ☐ **Yes** **or** ☐ **Medicaid** **Patient's Medicaid #**_____

Child's Primary Insurance	**Child's Secondary Insurance**
Subscriber's Name _____	Subscriber's Name _____
Subscriber's Relation to Patient _____	Subscriber's Relation to Patient _____
Subscriber # _____DOB _____	Subscriber # _____DOB _____
Employer _____	Employer _____
Insurance Co:_____	Insurance Co:_____
_____ (Street #) Ins. Phone #	_____ (Street #) Ins. Phone #
_____ (City, State) (Zip Code)	_____ (City, State) (Zip Code)
Insurance ID#:_____Group#:_____	Insurance ID#_____Group#:_____

Mother / Guardian	**Father / Guardian**
Name_____	Name_____
S.S.# _____ DOB _____	S.S.# _____ DOB _____
Occupation _____	Occupation _____
Business Name _____	Business Name _____
Business Location _____	Business Location _____
If different from patient: Home address_____ (Street #) _____ (City, State) (Zip Code)	If different from patient: Home address_____ (Street #) _____ (City, State) (Zip Code)
Home Phone ( ) _____	Home Phone ( ) _____

I understand that I am responsible for all charges incurred by me or my famiy regardless of insurance coverage and that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Comfort Kids on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

CERTIFICATION AND CONSENT FOR TREATMENT OF A MINOR

I certify that the above information is correct and I herby authorize the doctors to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examiniation including any necessary X-rays and after an explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until cancelled by either party.

Signature _____**Relationship to child**_____**Date**_____