|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Information | | | | | |
|  | *(First)* | *(Middle)* | *(Last)* | | *(Nickname)* |
| **Name:** |  |  |  | |  |
| **Sex** | M / F | | | **DOB (MM/DD/YYYY):** | |
| **Home Address:** | | | | | |
| **Siblings:** | | | | | |
| **Primary Reason for this dental visit:** | | | | | |
| **Whom may we thank for referring you to our office?** | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | Parent/Guardian Information |  |  |  | | --- | --- | | Father’s Name: | Mother’s Name: | |  |  | | Address (if different): | Address (if different): | | |  |  | | | Please fill in all, and check preferred method(s) of communication | | | | * Home Phone: | * Home Phone: | | | * Cell Phone: | * Cell Phone: | | | * Email: | * Email: | | | * Work Phone: | * Work Phone: | |   **Emergency Contact (and relationship to patient):** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Insurance Information | | | Insurance Company: | Group #: | | Subscriber Name: | Relationship to patient: | | Subscriber DOB: | Subscriber SSN or member #: |   For dental insurance subscribers, your date of birth ***and*** subscriber number/SSN are required by insurance companies to submit claims |

**Please read the following carefully before signing:**I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay this dental office the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services; and I am responsible for paying any co-payment, deductibles, and fees that my insurance does not cover. I hereby authorize release of any information, including the diagnosis and records of treatment rendered, to my insurance company. I agree that I am obligated to pay for all costs of dental treatment rendered on my behalf or my dependents. I have been informed of the $50.00 fee on checks returned from my bank (per RCW 62A.3-515&520). I have been informed that if the balance of my account remains unpaid for over 60 days, then the account will be charged 1% interest per month or $2.00 minimum, whichever is greater (per RCW 19.52), on the unpaid balance. I have been informed that if the balance of my account remains unpaid over 90 days, then the account may be surrendered to a collection agency. I have been informed that I will be charged a $50.00 fee if I miss an appointment or fail to notify the office within 24 hours of my appointment time.

SIGNED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

RELATIONSHIP TO CHILD