Patient Information

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits that will help keep their smile healthy for a lifetime.

Your Child/Primary Residence			Secondary Residence	
Parent's Name			Parent's Name	
Child's Name		Sex: ❑ M ❑ F	Relationship	
Birthdate		Age:	Home Address	
Home Address			City, ST, Zip	
City, ST, Zip			Home Phone	
Home Phone			Social Security #	
School		Grade	Email address	

❑ **MOTHER** ❑ Stepmother ❑ Guardian		❑ **FATHER** ❑ Stepfather ❑ Guardian	
Name		Name	
Home Phone		Home Phone	
Work Phone		Work Phone	
Cell Phone		Cell Phone	
Employer		Employer	
Occupation		Occupation	
SS#		SS#	
Date of Birth		Date of Birth	
Parent's Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed			

Primary Dental Insurance		Secondary Dental Insurance	
Insured Name		Insured Name	
Relationship		Relationship	
Date of Birth		Date of Birth	
SS#		SS#	
Employer		Employer	
Insurance Co.		Insurance Co.	
Group #		Group #	
Employee #		Employee #	
Ins. Co. Address		Ins. Co. Address	
Deductible	Annual Benefit	Deductible	Annual Benefit

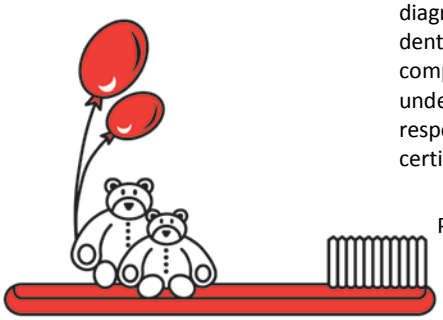
Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. **Full payment due at time of service.**

❑ Cash ❑ Check ❑ Visa ❑ MasterCard ❑ Discover Card

Late Charges: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of seven dollars will be assessed each month until the balance is paid. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

Cancelled Appointments: There will be a $40 charge for appointment failed or cancelled with less than 48 hours notice.



Authorization & Release: I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to my child, during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have read the above and certify that all statements are true and correct to the best of my knowledge.

Patient/Parent/Legal Guardian Signature: _____

Date: _____

Margaret Madonian, DDS