CHILD REGISTRATION

Gentle Dental Care P.C.

TODAY'S DATE: _____

****

CHILD'S NAME: _____ NICKNAME: _____

DATE OF BIRTH: ___/___/_____ SS# ___-___-_____ NAME OF SCHOOL: _____
day month year

REGISTRATION FOR ADDITIONAL CHILDREN:

CHILD'S NAME: _____ NICKNAME: _____

DATE OF BIRTH: ___/___/_____ SS# ___-___-_____ NAME OF SCHOOL: _____

CHILD'S NAME: _____ NICKNAME: _____

DATE OF BIRTH: ___/___/_____ SS# ___-___-_____ NAME OF SCHOOL: _____

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FATHER'S INFORMATION	MOTHER'S INFORMATION
NAME: _____	NAME: _____
DATE OF BIRTH: ___/___/___ SS# ___-___-_____	DATE OF BIRTH: ___/___/_____ SS# ___-___-_____
ADDRESS: _____	ADDRESS: _____
_____	_____
HOME PHONE: (___)_____ - _____	HOME PHONE: (_____)____-_____
CELL NO.: (___)_____ - _____	CELL NO.: (___)_____-_____
EMPLOYER: _____	EMPLOYER: _____
BUSINESS ADDRESS: _____	BUSINESS ADDRESS: _____
_____	_____
BUSINESS PHONE: (_____)_____-_____	BUSINESS PHONE: (___)_____-_____

********** PLEASE LIST INSURANCE INFORMATION UNDER THE PARENT WHO IS THE SUBSCRIBER **********

INSURANCE COMPANY: _____	INSURANCE COMPANY: _____
INSURANCE ADDRESS: _____	INSURANCE ADDRESS: _____
_____	_____
INS. TELEPHONE: (___)_____-_____	INS. TELEPHONE: (___)_____-_____
GROUP POLICY #: _____	GROUP POLICY #: _____
EFFECTIVE SINCE: _____	EFFECTIVE SINCE: _____

IN CASE OF EMERGENCY WHOM SHOULD BE NOTIFIED? _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Please Complete Back →

STATEMENT OF RESPONSIBILITY AND CONSENT

I hereby authorize and request the performance of dental services for the following person/persons:

_____

_____

_____

_____

_____

I also give my consent to any advisable and necessary dental procedure, medication, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic procedures or for dental treatment.

The Office Financial Policy is that we ask for payment at the time service is rendered. For those individuals who have insurance, this office will submit to all insurance companies and will only ask for the portion which your insurance is ***not estimated*** to cover at the time service is performed. If there is a difference in our estimate and what your insurance company actually covers, as sometimes happens, we will bill you for the difference. In the case of procedures which have a higher fee, such as crowns, bridges, and dentures, a short-term payment arrangement ***may*** be allowed.

I understand and acknowledge that I am financially responsible for the services provided for myself and/or the above named, regardless of insurance coverage. I have had the office financial policy explained to me and understand the guidelines of that policy.

_____ Date: _____

(SIGNATURE OF RESPONSIBLE PERSON)

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ASSIGNMENT OF INSURANCE BENEFITS

ORDER TO PAY INSURANCE:

TO: _____ GROUP POLICY #: _____

(INSURANCE COMPANY)

I hereby authorize and request your company to pay directly to Gentle Dental Care, P.C. the amount due me under terms of my policy issued by your company. Payment is authorized upon your receipt of each itemized statement for services rendered me or my family members covered by the same policy. Said payment, in whole or in part, shall be the same as if paid directly to me.

_____ Date: _____

(SIGNATURE OF INSURED)