FAMILY RECORD AND FINANCIAL RESPONSIBILITY

How did you choose our office (yelp, pediatrician, friend, etc)? ____
Reason for this appointment; ____

FAMILY RECORD

Name(s), age(s), date of birth(s) of child (ren) to be seen on your initial visit:
____

____

Has any family or friends been patients in our office in the past? If so, please list:
____

Patient(s) primary home address____

City ___________________________**State** ______**Zip code** __________ **Home phone#:**________________

Father's full name ____ Marital Status: M S D SEP (circle one)
Address (*if different*) ____
Home Phone _____________________Cell Phone _________________ E-mail _____________________________________
Work Phone ____________________Driver's License#: _____________________
Work address ____ Occupation _____________________

Mother's full name ____ Marital Status: M S D SEP (circle one)
Address (*if different*) ____
Home Phone _____________________Cell Phone _________________ E-mail _____________________________________
Work Phone ____________________ Driver's License#: ______________________
Work address ____ Occupation _____________________

Emergency Contact Name: _______________________ Relationship: _______________Phone:________________________

DENTAL INSURANCE INFORMATION

First Policy
Name of Subscriber __________________________________Relation to child: Father Mother Other__________ (circle one)

Social Security #____________________ Date of Birth: _______________ Insurance/Subscriber ID#___________________

Name of Insurance: __________________________________Employer__________________Group#___________________

Second Policy
Name of Subscriber _________________________________Relation to child: Father Mother Other____________ (circle one)

Social Security #____________________ Date of Birth: ______________ Insurance/Subscriber ID#__________________

Name of Insurance: __________________________________Employer__________________Group#___________________

INFORMED CONSENT

I authorize the use of this signature on all insurance submissions. I authorize my insurance company to pay Brea Pediatric Dental Practice and Orthodontics all insurance benefits otherwise payable to me for services rendered. I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance and that all payments are due when services are rendered. This consent is to remain in effect until canceled in writing.

Signature: ____________________________________ Date: _________________________