

Parent/Guardian Information

Mother (full name) _____

Check if you are Mother ____ Step Mother ____ Legal Guardian ____ Other _____

Address _____ City _____ State ____ Zip _____

Hm phone: _____ Wk phone: _____ X _____ Cell: _____

SS #: _____ Drivers License St & # _____ Date of Birth _____

E-mail: _____ Employer: _____

Father (full name) _____

Check if you are Father ____ Step Father ____ Legal Guardian ____ Other _____

Address _____ City _____ State ____ Zip _____

Hm phone: _____ Wk phone: _____ X _____ Cell: _____

SS #: _____ Drivers License St & # _____ Date of Birth _____

E-mail: _____ Employer: _____

Nearest relative not living with you. Name _____ Phone #: _____

Relationship to patient _____

Primary Dental Insurance Information

Insurance Company _____

Address _____

Phone: _____

Group #: _____

Subscriber's Name: _____

Subscriber's ID #: _____

Subscriber's Date of Birth: _____

Employer: _____

Secondary Dental Insurance Information

Insurance Company _____

Address _____

Phone: _____

Group #: _____

Subscriber's Name: _____

Subscriber's ID #: _____

Subscriber's Date of Birth: _____

Employer: _____

* Please be aware, secondary insurance may not cover the balance of charges after your primary insurance pays. You may have a portion to pay for treatment.

PLEASE NOTE: Your insurance is billed as a courtesy; you are responsible for your child's account

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the Children's Landing Pediatric Dentistry and associates to perform the necessary dental services my child may need.

Signature of Parent or Legal Guardian

Date