

Tell Us About Your Child

Child's Name _____
Last First MI

Birth Date _____ Child's Age _____

Preferred Name _____ Male Female

SS # _____

School _____ Grade _____

Lives with: Mom/Dad/Grandparent/Foster/Other: (circle) _____

Child's Address _____
Street/PO Box/Apt #

City State Zip

Child's Home # _____

Email _____

Parent/Guarantor Information

Marital Status: (circle) Married/Single/Divorced/Widowed

Name _____
Last First MI

Relationship to Child _____

Birth Date _____ Home # _____

Work # _____ Cell # _____

Address _____
Street/PO Box/Apt #

City State Zip

Email _____

SS # _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****Please initial here if you refuse to sign this form _____****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name _____

Employer _____

Program/Policy # or Group ID # _____

Employee Name _____

Employee Date of Birth _____

Employee SS # _____

Secondary Dental Insurance

Insurance Co. Name _____

Employer _____

Program/Policy # or Group ID # _____

Employee Name _____

Employee Date of Birth _____

Employee SS # _____

I authorize Smile Dailey Dental to release any information needed to process my insurance claims. Smile Dailey Dental will file my insurance as a courtesy, however, I understand that I am ultimately responsible for payment of all services rendered.

I assign benefits payable, for the services provided, to Smile Dailey Dental or the provider.

Signature _____

Date _____

Responsible Parties: Scheduling Appointments (circle)

Mother/Father/Grandparent/Foster/Other

Name _____
Last First MI

Accompanying Child to Appointments (circle)

Mother/Father/Grandparent/Foster/Other

Name _____
Last First MI

Referral

Whom may we thank for recommending us to you?
