Dentistry for Children & Young Adults

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Mother's Name ________________________________ Soc. Sec. # ______________ Birthdate ____________
(Last) (First) (Middle)

Address ________________________________ City ________________ State ______ Zip ________

Home Phone # ______________ Cell # ______________ E-Mail ________________________

Employer ________________________________ Work Phone # ______________ Ext. ________

Occupation ____ How Long? ____________

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Father's Name ________________________________ Soc. Sec. # ______________ Birthdate ____________
(Last) (First) (Middle)

Address ________________________________ City ________________ State ______ Zip ________

Home Phone # ______________ Cell # ______________ E-Mail ________________________

Employer ________________________________ Work Phone # ______________ Ext. ________

Occupation ____ How Long? ____________

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Legal Guardian ________________________________ Soc. Sec. # ______________ Birthdate ____________
(If Applicable) (Last) (First) (Middle)

Address ________________________________ City ________________ State ______ Zip ________

Home Phone # ______________ Cell # ______________ E-Mail ________________________

Employer ________________________________ Work Phone # ______________ Ext. ________

Occupation ____ How Long? ____________

Child resides with: ❑ Mother ❑ Father ❑ Both ❑ Legal Guardian

PRIMARY INSURANCE

Subscriber ________________________________

Soc. Sec. ________________________________

Insurance Co. Name ________________________

Group # ________________________________

SECONDARY INSURANCE

Subscriber ________________________________

Soc. Sec. ________________________________

Insurance Co. Name ________________________

Group # ________________________________

As a courtesy to you we will be happy to bill your dental insurance for you provided you have completed this form in its entirety.

I hereby authorize my insurance benefits to be paid directly to The Children's Choice. I understand I am financially responsible for noncovered services, as well as any remaining balance after my insurance company has paid.

Legally Responsible Person ____ Date ______________