

**PATIENT INFORMATION SHEET**

**Child's Name** \_\_\_\_\_ Social Security # \_\_\_\_\_

Residence – Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

Name of Referring Doctor \_\_\_\_\_

Parent's or Guardian's Names \_\_\_\_\_

Responsible Party's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Father's Social Security #** \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Father Employed By \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Telephone \_\_\_\_\_

Father's Dental Insurance Co. \_\_\_\_\_

Father's Medical Insurance Co. \_\_\_\_\_

**Mother's Social Security #** \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Mother Employed By \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Telephone \_\_\_\_\_

Mother's Dental Insurance Co. \_\_\_\_\_

Mother's Medical Insurance Co. \_\_\_\_\_

**Charges and Payments Explanation**

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of the insurance coverage. Should my insurance not cover all my fees, I will remain responsible for the remaining balance and agree to pay in full 90 days from service date. If no insurance coverage, it is customary to pay for services when rendered unless other arrangements have been made in advance.

**Authorization To Pay Physician**

I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits. I understand that I am financially responsible for the charges not covered by this authorization.

**Authorization To Release Information**

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to my insurance company.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent's or Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\* COMPLETE BOTH SIDES OF THIS SHEET \*\*\*\*\*

