ANNE R. LEE, DDS :: PEDIATRIC DENTISTRY

Patient's last name______________________

Address________________________________

City______________________ Zip__________

Child 1 First name____________________________

Nickname_____________________

Birthdate________________ Sex: F M

Child 2 First name_________________________

Nickname_____________________

Birthdate________________ Sex: F M

Child 3 First name____________________________

Nickname_____________________

Birthdate________________ Sex: F M

Responsible Party

With whom does patient live?________________

Who brought patient today?_________________

Person responsible for account___________________

<u>Parent or Guardian Information</u>

Parent 1 Name__________________________

Address_________________________________

City______________________ Zip________

Mobile #_______________________

Home #_______________________

Work #_______________________

Email_________________________

Driver's license #________________________

Parent 2 Name__________________________

Address_________________________________

City______________________ Zip________

Mobile #_______________________

Home #_______________________

Work #_______________________

Email_________________________

Driver's license #_________________________

Primary Insurance

Name of insured_________________________

Birthdate of insured_________________

ID number or SSN_____________________

Employer__________________________

Carrier________________________

Group #____________________

Secondary Insurance

Name of insured_________________________

Birthdate of insured_________________

ID number or SSN_____________________

Employer__________________________

Carrier________________________

Group #____________________

Whom may we thank for referring you to our office?________________________________

- *I have reviewed the information on this form and it is accurate to the best of my knowledge.*
- *I authorize and request my insurance company to pay my insurance benefits directly to the dental office. Furthermore, I understand that <u>even though I may have dental insurance, I am responsible for all financial obligations that may arise as a result of any dental treatment provided for my child.</u>*
- *I acknowledge that the Dental Materials Fact Sheet has been made available to me.*

Signature of parent/guardian_______________________________ **Date**_____________________