Today's Date_____

Patient's Name_____ **Male / Female** **Date of Birth**_____

Patient's Street Address_____

City, State & Zip Code_____

Email Address for Appt. Confirmation:_____

Cell Phone for Text Reminders:_____

Father's Name_____ Birthdate_____

Employer_____ Social Security #_____

Home Phone_____ Work_____ Cell _____

Father's Address if Different than Child's_____

Name of Dental Insurance Company_____

Group or Policy #_____ Insurance Phone_____

Insurance Co. Address_____

Mother's Name_____ Birthdate_____

Employer_____ Social Security #_____

Home Phone_____ Work_____ Cell _____

Mother's Address if Different than Child's_____

Name of Dental Insurance Co._____

Group or Policy #_____ Insurance Phone_____

Insurance Co. Address_____

Name of Person to Contact in Case of Emergency_____

Emergency Phone_____ Relationship_____

How Did You Hear About Us? Drive By___ Internet___ Insurance Co___ Dr./Friend_____

Our office is happy to assist patient's families who are covered by dental insurance. As a courtesy to you we will submit claims to your primary carrier and accept assignment of benefits. Our office requires that you pay your estimated portion of your bill at the time of service. Total payment of your child's charges is your responsibility, regardless of what insurance pays. Your insurance policy is a contract between your employer, you, and the insurance company. Any remaining balance not paid by insurance will be billed to you**. Please be aware, our office will not submit statements for billing to any one other than the person responsible for filling out each child's medical/dental history and other questionnaires.**

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND GIVE MY CONSENT FOR MY CHILD, _____, TO HAVE DENTAL PROCEDURES PERFORMED BY DR. WITTE AND HIS STAFF. I AUTHORIZE DENTAL INSURANCE BENEFITS TO BE PAID TO DR. WITTE:

Signature_____ Relationship to Patient_____

Print Name_____ Date_____