

Today's Date _____

Patient's Name _____ Male / Female Date of Birth _____

Patient's Address _____

School Patient Attends _____ Grade _____

Father's Name _____ Birthdate _____

Employer _____ Social Security # _____

Home Phone _____ Work/Cell _____

Father's Address if Different than Child's _____

Name of Insurance Company _____

Group or Policy # _____ Phone _____

Address of Insurance Co. _____

Mother's Name _____ Birthdate _____

Employer _____ Social Security # _____

Home Phone _____ Work/Cell _____

Mother's Address if Different than Child's _____

Name of Insurance Co. _____

Group or Policy # _____ Phone _____

Address of Insurance Co. _____

Any Brothers or Sisters? _____ Ages _____

Name of Person to Contact in Case of Emergency _____

Phone _____ Relationship _____

How Did You Hear About Us? Phone Book ___ Internet ___ Theater Ad ___ Referred By _____

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. Total payment of your child's charges are your responsibility, regardless of what insurance pays. Your insurance policy is a contract between your employer, you, and the insurance company. Our office requires that you pay your estimated portion of your bill at the time of service. 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 _____ TO HAVE DENTAL PROCEDURES PERFORMED BY DR. WITTE AND HIS STAFF:

Signature _____ Date _____