# WELCOME TO OUR OFFICE!

## PLEASE TELL US MORE ABOUT YOUR CHILD

**Child's name:** _____ **Sex: M (_) F (_)**

**SSN:** _____ **Birth date:** _____/_____/_____

**Home Address:** _____**City:**_____**State:**____ **Zip:** _____

**Phone:** _____ **School:** _____ **Grade:** _____

**Referred by:** _____

## PARENT/GUARDIAN INFORMATION

***Please circle one: MOTHER STEPMOTHER GRANDMOTHER/GUARDIAN***

**Name:** _____ **SSN:** _____ **DOB:**_____/_____/_____
**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
**Employed by:** _____ **Occupation:** _____
**Driver's License #:** _____ **State:** _____ **Exp Date:** _____

***Please circle one: FATHER STEPFATHER GRANDFATHER/GUARDIAN***

**Name:** _____ **SSN:** _____ **DOB:**_____/_____/_____
**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
**Employed by:** _____ **Occupation:** _____
**Driver's License #:** _____ **State:** _____ **Exp Date:** _____

## DENTAL INSURANCE

**Insurance Co. Name:** _____ **Phone:**_____
**Address:** _____
**Group #:** _____ **ID, Plan or Policy #:**_____
**Insured's Name:** _____ **SSN:** _____ **Insured's DOB:**_____
**Insured's Employer:** _____ **Relation to Child:** _____

## AUTHORIZATION

I certify the truth of all information provided. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purposes of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Kids 1st Dentistry, otherwise payable to be. **I understand that my dental insurance carrier may pay less than the actual amount billed for services and may not cover all services provided.** I understand I am financially responsible for payment of services not paid, in whole or part, by my dental care payor.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE