



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

<i>Please circle one: MOTHER STEPMOTHER GRANDMOTHER/GUARDIAN</i>	
Name: _____	SSN: _____ DOB: ____/____/____
Address: _____	City: _____ State: ____ Zip: _____
Employed by: _____	Occupation: _____
Driver's License #: _____	State: _____ Exp Date: _____
<i>Please circle one: FATHER STEPFATHER GRANDFATHER/GUARDIAN</i>	
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