SPRINGFIELD PEDIATRIC DENTISTRY

Child's Information and Insurance

Child's Name: _____ Nickname: _____
Last First M

Male or Female Birthdate: _____ Age: _____ Social Security #: _____

Address: _____
Street Apt#/Lot# City State Zip Code

Please provide Email and Cellphone number for confirmation of appointments:

Email: _____ Cellphone number: _____

Do you have any siblings that come to this office? What are their names?

_____

Whom can we thank for your referral? _____

Dental Insurance: _____ ID#_____

Mother/Guardian Information:

Name: _____ Phone: _____
Last First Home Cell Work

Address: _____
Street Apt#/Lot# City State Zip Code

Birthdate: _____ Social Security #: _____ Employer: _____

Dental Insurance: _____ Group #: _____ ID#: _____

Father/Guardian Information:

Name: _____ Phone: _____
Last First Home Cell Work

Address: _____
Street Apt#/Lot# City State Zip Code

Birthdate: _____ Social Security #: _____ Employer: _____

Dental Insurance: _____ Group #: _____ ID#: _____

Emergency Contacts or Nearest Relative:

1. _____
Name Cell Phone# Home# Relationship

2. _____
Name Cell Phone# Home# Relationship

3. _____
Name Cell Phone# Home# Relationship

I here by authorize payment to Springfield Pediatric Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and preform such diagnostic, photographic, radiographic and therapeutic procedures as may be necessary for proper dental care. The information given on the following forms to be the best of my knowledge. I grant the right of the dentist to release the information about the dental treatment to the third party payors and/or other health professionals. I understand that the office complies with all HIPPA rules and regulations and I may request a copy of those at anytime.

Parent/Guardian Signature: _____ Date: _____

Dr. Andrea Myers, DDS, MSD
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