PARENT OR GUARDIAN INFORMATION

FATHER **Name**____
Last First Middle

Address____
(where you receive mail) Street or 911 City State Zip

SS#____/____/____ **BIRTHDATE**___/___/_____ **DRIVER'S LICENSE#**__________

TELEPHONE: **HOME**__________________ **WORK**__________________

CELL__________________

E-MAIL ADDRESS____

PLACE OF EMPLOYMENT______________________________ **OCCUPATION**__________________

DENTAL INSURANCE COMPANY____

MOTHER **Name**____
Last First Middle

Address____
(where you receive mail) Street or 911 City State Zip

SS#____/____/____ **BIRTHDATE**___/___/_____ **DRIVER'S LICENSE#**__________

TELEPHONE: **HOME**__________________ **WORK**__________________

CELL__________________

E-MAIL ADDRESS____

PLACE OF EMPLOYMENT______________________________ **OCCUPATION**__________________

DENTAL INSURANCE COMPANY____

In the event of an emergency, whom (other than those listed above) should we contact?
NAME______________________________ RELATIONSHIP TO CHILD__________________
TELEPHONE #____

PAYMENT OF PROFESSIONAL FEES

► **I understand that payment is due at the time of service.**

► **Any amount estimated NOT to be covered by insurance will be due at the time of service.**

How may we expect your payment? **(Please check one)**

☐ **Cash or check** ☐ **Credit Card** ☐ **Insurance** ☐ **Medicaid**

► The information I have given is correct to the best of my knowledge that it will be held in the strictest of confidence. I also understand that it is my responsibility to inform this office of any changes in my child's medical status, address, or any other personal information. I authorize the dental staff to perform any dental services that they may deem necessary.

► I give permission to East Texas Children's Dentistry, P. A., to use my child's first name and picture on their website or for any advertis announcements and/or educational use.

► By signing this form, I agree to take full financial responsibility for this child's account. I understand that my estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is payable by me.

► I hereby authorize payment of dental insurance benefits, if any, to be made directly to East Texas Children's Dentistry, P.A.