PARENT OR GUARDIAN INFORMATION

FATHER:

NAME: _____
Last *First* *Middle Initial*

MAILING ADDRESS: _____
Street or 911 *City* *State* *Zip Code*

SS# _____ - _____ - _____ **BIRTHDATE** _____/_____/_____ **DRIVER'S LICENSE#** _____

HOME PHONE #: _____ **CELLPHONE #:** _____ **WORK PHONE #:** _____

E-MAIL ADDRESS: _____

PLACE OF EMPLOYMENT: _____ **OCCUPATION:** _____

DENTAL INSURANCE COMPANY _____

MOTHER:

NAME: _____
Last *First* *Middle Initial*

MAILING ADDRESS: _____
Street or 911 *City* *State* *Zip Code*

SS# _____ - _____ - _____ **BIRTHDATE** _____/_____/_____ **DRIVER'S LICENSE#** _____

HOME PHONE #: _____ **CELLPHONE #:** _____ **WORK PHONE #:** _____

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: _____ Phone: _____

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 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 advertising 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.

_____ / _____ _____
Signature Print Name Date