Patient Information

First Name:_____

Last Name: _____

Date of Birth:_____

Preferred Name:_____

Address:_____

City:_____

State:_____

Zip:_____

Contract Information

Mother's First & Last Name:_____

Mother's Address (If different from patient):

_____

_____

Mother's Home Phone:_____

Mother's Work Phone:_____

Mother's Cell Phone:_____

Mother's Email:_____

Father's First & Last Name:_____

Father's Address (If different from patient):

_____

_____

Father's Home Phone:_____

Father's Work Phone:_____

Father's Cell Phone:_____

Father's Email:_____

Name of Responsible Party:_____

Name of Head of Household:_____ _____

Emergency Contact:_____

Emergency Contact Phone Number:_____

Patient's Medical Doctor Name/Facility:_____

Medical Doctor's Phone Number:_____

PRIMARY INSURANCE

Primary Policy Holder's Name:_____

Place of Employment:_____

Name of Dental Insurance:_____

Primary Insurance ID Number:_____

Insurance Company's Phone Number:_____

Group Number:_____

Policy Holder's Social Security Number:_____

Policy Holder's Date of Birth:_____

SECONDARY INSURANCE

Secondary Policy Holder's Name:_____

Place of Employment:_____

Name of Dental Insurance:_ _____

Secondary Insurance ID Number:_____

Insurance company's Phone Number:_____

Group Number:_____

Policy Holder's Social Security Number:_____

Policy Holder's Date of Birth:_____

MEDICAL HISTORY

Allergies (Please List ALL):

_____

_____

_____

Medical Conditions (Please List ALL):

_____
_____
_____

Medications (Please List ALL):

_____
_____
_____

REFERRAL SOURCE

Who referred you to our office?_____

How did you hear about Centerville Pediatric Dentistry?_____

POLICIES	**YES**	**NO**
I have read and understand the Privacy Policy:	☐	☐
I have read and understand the Financial Policy:	☐	☐
I have read and understand the Attendance Policy:	☐	☐
I give permission to be contacted by text and/or email:	☐	☐

By signing below, I hereby authorize assignment of insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. I hereby authorize release of any or all medical or dental information required to process an insurance claim or to another dentist or medical doctor. I have been informed that my private information will only be disclosed in a legal manner. I attest that I have legal custody of the patient. I authorize Centerville Pediatric Dentistry to forward x-rays and Dental history upon my request.

Printed Name:_____

Signature:_____ Date:_____