Welcome to FUNtastic Dental and Orthodontics!

GENERAL PATIENT INFORMATION

Child's First Name **Last Name** Preferred Name/Nickname Sex Age D.O.B.

Child's First Name **Last Name** Preferred Name/Nickname Sex Age D.O.B.

Child's First Name **Last Name** Preferred Name/Nickname Sex Age D.O.B.

Home Address **City, State, Zip Code**

( ) **Home Phone** ( ) **Cell Phone** **Email Address**

Name of adult accompanying child today ***Relationship*** ***Previous Dentist Name****/Phone Number* *Date of last dental visit*

How did you hear about our office? *(Relative/Friend's Name, Website, Facebook, etc.)*

Reason for today's visit *(Consultation, Dental Exam, Dental cleaning, Dental x-rays, etc.)*

I have received a copy of the Dental Materials Fact Sheet as required by law.

Signature **Date**

PARENT / GUARDIAN INFORMATION

Parent/Guardian's Name Relationship

Mailing Address City, State, Zip Code

Home Number Cell Number

D.O.B. Age Marital Status

S.S.N. Driver's License #

Parent/Guardian's Name Relationship

Mailing Address City, State, Zip Code

Home Number Cell Number

D.O.B. Age Marital Status

SSN Driver's License #

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Full Name

Employer's Name Insurance Company

Subscriber ID # Group #

D.O.B. Social Security #

Secondary Policy Holder's Full Name

Employer's Name Insurance Company

Subscriber ID # Group #

D.O.B. Social Security #

I understand the information that I have given above is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status, contact information, and insurance information. I authorize the dental staff of FUNtastic Dental and Orthodontics to perform the necessary dental services my child may need. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Name of Parent/Guardian **Signature of Parent/Guardian** **Date**