CRAWFORD D.D.S.

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Welcome

Thank you for selecting our dental healthcare team - we are pleased to welcome your child to our practice! To help us better serve the needs of your child and meet his/her dental healthcare needs, please complete the following form. If you have any questions or need assistance, please ask us - we are happy to help!

Your Child

Child's Name ______________________________

Wishes to be called ______________ Sex ❑ F ❑ M

Birthdate ________________ Age ________

Child's Home Address ______________________

City ________________ State/Zip ________

Phone ________________

Whom may we thank for referring you?

____

Person Responsible for Scheduling?

Name ______________________________

Relationship to patient ______________________

How can we best reach you?

❑ Cell ❑ Email ______________

❑ Pager ❑ Work ❑ Home

Time of Day ________________

Mother

❑ Stepmother ❑ Guardian

Name ______________________________

Home Phone ______________ Cell Phone ______________

Work Phone ______________ Ext. # ______________

Pager ______________ E-Mail ______________

Employer ______________ Occupation ______________

SS# ______________ Birthdate ______________

Marital Status

❑ Single ❑ Married ❑ Other ________

Father

❑ Stepfather ❑ Guardian

Name ______________________________

Home Phone ______________ Cell Phone ______________

Work Phone ______________ Ext. # ______________

Pager ______________ E-Mail ______________

Employer ______________ Occupation ______________

SS# ______________ Birthdate ______________

Marital Status

❑ Single ❑ Married ❑ Other ________

Responsible Party Other Than Listed

Name ______________________________

Relationship to patient ______________________

Birthdate ______________ Soc. Sec. # ______________

Address ______________________________

City ______________ State/Zip ______________

Employer ______________ Occupation ______________

Work Phone ______________ Ext. # ______________

Home Phone ______________ Cell Phone ______________

Emergency Contact

Name ______________________________

Phone Number ______________________________

Relation to patient ______________________________

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Dental Insurance Information

Primary Insurance

Name of Insured ____________________
Relationship to Patient ____________________
Insured's Birthdate ____________________
Insurance ID. # ____________________
Employer ____________________
Occupation ____________________
Insurance Company ____________________
Group # ____________________
Ins. Co. Address ____________________
____
Ins. Co. Phone ____________________

Secondary Insurance

Name of Insured ____________________
Relationship to Patient ____________________
Insured's Birthdate ____________________
Insurance ID. # ____________________
Employer ____________________
Occupation ____________________
Insurance Company ____________________
Group # ____________________
Ins. Co. Address ____________________
____
Ins. Co. Phone ____________________

Authorization and Release

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____

Signature of parent/guardian   Date

Thank you for filling out this form completely. The information you have provided will help us serve your child's dental healthcare needs more effectively and efficiently.

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