BriteStars Pediatric Dentistry

Shining Stars Pediatric Dentistry

Welcome Form

We welcome our practice. Please take a few minutes to fill out the forms completely

Patient's Name _____ Last Name _____Nick Name_____

Sex ☐ M ☐ F Date of Birth _____ Age_____

Address _____

City_____ State _____ Zip Code _____

Home Phone (_____) Cell # (_____) Email _____

Name of the child's pediatrician _____ Physician's phone # _____

Notify in case of emergency _____ _____ Phone # _____

How do they find out about us? Please name: _____

Parents or Legal Guardian Information

Name of Mother _____ Name of Father _____

Employer_____ Occupation _____ Employer_____Occupation _____

……

Policy Holder's Name _____ *Name of Insurance* _____

Billing Address _____ *ID#*_____ *Group #*_____

*SocSec#*_____ *BirthDate*_____ *Insurance Phone#*_____

Authorization * I have reviewed the information in this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthy dental treatment. If there is any change in my medical condition, I will inform the dentist. * I authorized my insurance company to pay the dentist or dental group all insurance benefits that would otherwise be paid to me for the services rendered. * I authorize the use of this signature in all insurance presentations. * I authorize the dentist to disclose all information necessary to ensure payment of benefits. I understand that I am financially responsible for all charges, whether or not paid for by insurance.

Signature _____*Relationship*_____ *Date:*_____