

## Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name \_\_\_\_\_  
(Please Print)

Signature \_\_\_\_\_

Birthdate \_\_\_\_\_

Date \_\_\_\_\_  
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## 1 About Your Child

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
LAST FIRST M.I.

Child's Nickname: \_\_\_\_\_  Boy  Girl

Child's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's Home Phone #: (\_\_\_\_) \_\_\_\_\_

Child's SS#: \_\_\_\_\_

Child's Address: \_\_\_\_\_  
HOME ADDRESS

CITY STATE ZIP

Referred By: \_\_\_\_\_  
(If doctor, please give address & phone number.)

## 2 Insurance Information

### Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Does either policy cover Orthodontics?  Yes  No

### Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

## 3 Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child?  Yes  No

How many Brothers/Sisters? \_\_\_\_\_ Age(s): \_\_\_\_\_

MOTHER'S NAME  STEP MOTHER  GUARDIAN EMAIL ADDRESS

( CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(\_\_\_\_) (\_\_\_\_) (\_\_\_\_)  
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

EMPLOYER'S ADDRESS CITY STATE ZIP

FATHER'S NAME  STEP FATHER  GUARDIAN EMAIL ADDRESS

( CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(\_\_\_\_) (\_\_\_\_) (\_\_\_\_)  
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

EMPLOYER'S ADDRESS CITY STATE ZIP

## 4 Account Information

Person ultimately responsible for account

Name: \_\_\_\_\_ RELATION TO CHILD

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(\_\_\_\_) (\_\_\_\_) (\_\_\_\_)  
WORK PHONE #: EXT. CELL PHONE #:

Payment method:  Cash  Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my 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 (if offered at this office).

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