Welcome!

We are pleased to welcome you to our practice. Please fill out this form completely. Don't hesitate to ask us if you have any questions. Our goal is to make you and your child's dental experience "A Walk in the Park!"

CONFIDENTIAL PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	M/F
Street Address:	City:	State:	Zip:
Home Phone:	Birth date:	Social Security #:	
Child prefers to be called:			

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Parent/Guardian Last Name: First: Middle:			❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / other
Home Phone#: ( )	Work Phone#: ( )	Cell Phone#: ( )	Birth date:	Relationship to patient:
Street address: (If different from above)		Social Security no.:		E-mail address:
P.O. Box:	City:		State:	ZIP Code:
Occupation:	Employer:	Employer address:		Employer phone#:
Parent /Guardian Last Name: First: Middle:			❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / other
Home Phone#: (If different from above)	Work Phone # ( )	Cell Phone #: ( )	Birth date:	Relationship to Patient:
Address: (If different from above)		Social Security no:		E-Mail address: (If different from above)
Occupation:	Employer:	Employer address:		Employer phone#:

Who can we thank for referring you to our office?
(please check applicable boxes if more than one source)
❑ Referred by another office (name):
❑ Insurance Plan
❑ Hospital
❑ Friend (name):
❑ Family (name):
❑ Location:
❑ Advertisement:

CONFIDENTIAL INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No		If yes, does patient have dual coverage? ❑ Yes ❑ No	
Name of primary insurance:	Insurance Company Address:		Insurance Co. phone#:
Subscriber's name:	Subscriber's ID:	Birth date: / /	Group no.:
Patient's relationship to subscriber: ❑ Child ❑ Other			
Name of secondary insurance (if applicable):	Insurance Company Address:		Insurance Co. phone#:
Subscriber's name:	Subscriber's ID:	Birth date: / /	Group no.:
Patient's relationship to subscriber: ❑Child ❑Other			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

EMAIL CONSENT- I understand I can change my consent at anytime.

☐ I consent and accept the risk in receiving information via email. I consent to receiving appointment reminders via email or text.

☐ I do not consent to receiving any information via email.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. I also authorize Children's Dentistry of San Diego and my insurance company to release any information required to process my claims.

Parent/Guardian Signature:	Date: