MOFFITT CHILDREN'S DENTISTRY

PATIENT NAME(S)

Name (first - middle initial - last)	Birth date	Sex	Name (first - middle initial - last)	Birth date	Sex
_____	___/___/___	___	_____	___/___/___	___
_____	___/___/___	___	_____	___/___/___	___
_____	___/___/___	___	_____	___/___/___	___
_____	___/___/___	___	_____	___/___/___	___

PARENT INFORMATION

Father's Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Birth date:_____SSN:____/___/_____

Employer:_____

Occupation:_____

Work Phone:_____Ext:_____

Email:_____

Mother's Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Birth date:_____SSN:____/___/_____

Employer:_____

Occupation:_____

Work Phone:_____Ext:_____

Email:_____

Who does the child/children live with? Both Parents Mother Father Other_____

In case of emergency, who should we contact? Name:_____Phone:_____
(someone not living in the household)

INSURANCE INFORMATION

Primary Dental Insurance

Policy Owner's Name:_____

Relationship to Patient(s):_____

Birth date:_____SSN:____/___/_____

Policy Owner's Employer:_____

Employer's Address:_____

City:_____State:_____Zip:_____

Work Phone:_____

Insurance Co. Name:_____

Insurance Co. Address:_____

City:_____State:_____Zip:_____

Insurance Co. Phone: (____)_____

Group, Policy, Plan, or Union #:_____

Secondary Dental Insurance

Policy Owner's Name:_____

Relationship to Patient(s):_____

Birth date:_____SSN:____/___/_____

Policy Owner's Employer:_____

Employer's Address:_____

City:_____State:_____Zip:_____

Work Phone:_____

Insurance Co. Name:_____

Insurance Co. Address:_____

City:_____State:_____Zip:_____

Insurance Co. Phone: (____)_____

Group, Policy, Plan, or Union #:_____

AUTHORIZATION

I certify that above information is complete and accurate. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand by signing this form I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of Responsible Party: _____ Date: _____