PATIENT ACQUAINTANCE INFORMATION

Patient's Name ______________________________ Phone No. ______________

Patient's Date of Birth ______________________ Patient's Social Securtiy # ______________

Patient's Address ____
Street # City, State Zip Code

Other Children in the family: (Are any of them patients of this practice ☐ Yes ☐ No)

Name ______________________________ Age________ Birthday ______________

______________________________ Age________ Birthday ______________

Patient's Pediatrician ______________________ Pediatrician's Phone Number______________

Parent's Dentist ______________________

Is Patient covered by dental insurance? ☐ **No** ☐ **Yes or** ☐ **Medicaid Patient's Medicaid #**__________

Child's Primary Insurance	**Child's Secondary Insurance**
Subscriber's Name ______________________	Subscriber's Name ______________________
Subscriber's Relation to Patient ______________	Subscriber's Relation to Patient ______________
Subscriber # ____________ DOB ____________	Subscriber # ____________ DOB ____________
Employer ______________________	Employer ______________________
Insurance Co:______________________	Insurance Co:______________________
______________________ (Street #) Ins. Phone #	______________________ (Street #) Ins. Phone #
______________________ (City, State) (Zip Code)	______________________ (City, State) (Zip Code)
Insurance ID#:____________ Group#:__________	Insurance ID#____________ Group#:__________

Mother / Guardian	**Father / Guardian**
Name______________________	Name______________________
S.S.# ______________ DOB __________	S.S.# ______________ DOB __________
Occupation ______________________	Occupation ______________________
Business Name ______________________	Business Name ______________________
Business Location ______________________	Business Location ______________________
If different from patient: Home address______________________ (Street #)	If different from patient: Home address______________________ (Street #)
______________________ (City, State) (Zip Code)	______________________ (City, State) (Zip Code)
Home Phone ( ) ______________	Home Phone ( ) ______________

I understand that I am responsible for all charges incurred by me or my famiy regardless of insurance coverage and that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Comfort Kids on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

CERTIFICATION AND CONSENT FOR TREATMENT OF A MINOR

I certify that the above information is correct and I herby authorize the doctors to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examiniation including any necessary X-rays and after an explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until cancelled by either party.

Signature ______________________ **Relationship to child**______________ **Date**__________