A Tooth Doctor for Kids
Pediatric Dentistry

19010 Brookhurst St.
Huntington Beach, CA 92646
714 968-8989
714 845-9055 *Fax*
www.atoothdoctorforkids.com

Family Information

PATIENT'S FULL NAME			SEX	DATE OF BIRTH
ADDRESS	CITY		ZIP CODE	HOME PHONE ( )
PARENT(1) FULL NAME	ADDRESS (IF DIFFERENT FROM PATIENT'S)		HOME PHONE ( )	CELL PHONE ( )
PARENT(1) EMPLOYER	BUSINESS ADDRESS		PARENT(1) WORK PHONE ( )	OCCUPATION
PARENT(1) DATE OF BIRTH	PARENT(1) SOCIAL SECURITY #	PARENT(1) DRIVER'S LICENSE #	E-MAIL ADDRESS	
PARENT(2) FULL NAME	ADDRESS (IF DIFFERENT FROM PATIENT'S)		HOME PHONE ( )	CELL PHONE ( )
PARENT(2) EMPLOYER	BUSINESS ADDRESS		PARENT(2) WORK PHONE ( )	OCCUPATION
PARENT(2) DATE OF BIRTH	PARENT(2) SOCIAL SECURITY #	PARENT(2) DRIVER'S LICENSE #	E-MAIL ADDRESS	
NAME & PHONE OF CLOSE RELATIVE OR FRIEND			SIBLINGS NAME & AGE	
HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN THIS OFFICE BEFORE? ❒ YES ❒ NO IF YES, NAME				

Authorization & Financial Responsibility

IS YOUR CHILD COVERED BY A DENTAL PLAN? ❒ YES ❒ NO		EMPLOYERS NAME, (IF PLAN IS THROUGH YOUR EMPLOYER. IF NOT, PLEASE PUT "SELF")?	
NAME OF PARENT INSURED	NAME OF INSURANCE CARRIER	GROUP OR POLICY #	MEMBER ID #
SECONDARY INSURANCE		EMPLOYERS NAME, (IF PLAN IS THROUGH YOUR EMPLOYER. IF NOT, PLEASE PUT "SELF")?	
NAME OF PARENT INSURED (1)	NAME OF INSURANCE CARRIER	GROUP OR POLICY #	MEMBER ID #

I hereby authorize A Tooth Doctor For Kids and its associates to perform any and all treatment for my above named child and consent to such methods, drugs, and agents as may be indcated in connection with his/her dental care. This consent shall remain in effect until cancelled.

Please be aware that our office requires a 48 business hour notice for changing or cancelling an appointment. This does not include the time we make our appointment reminder phone calls. Failure to contact our offices within 48 business hours may result in a patient charge.

I understand that payment is expected for service rendered at the time of each visit and take financial responsibility of the patient named above. Financial arrangements may be made following the diagnosis. A monthly finance charge of 1 1/2% is added to all balances after 30 days (APR of 18%). A late charge may also be added. For patients with dental insurance: On your behalf, our office will bill your insurance after treatment is complete. Often these payments are not received until 2-3 months after being submitted for payment. Please note you are responsible for the total charges until we receive payment from your carrier. Therefore, we ask that you pay your estimated share of your treatment as treatment is rendered.

SIGNATURE OF RESPONSIBLE PARTY (PARENT OR LEGAL GUARDIAN)	RELATIONSHIP TO PATIENT	DATE

please complete the other side of this form