



# Welcome!

We are pleased to welcome you to our practice.  
 Please take a few minutes to 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:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> 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:	Relationship to Patient:		
Occupation:	Employer:	Employer address:			Employer phone#:	
<b>Who can we thank for referring you to our office?</b> (please check applicable boxes if more than one source) <input type="checkbox"/> Referred by another office (name): <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital				<input type="checkbox"/> Friend (name): <input type="checkbox"/> Family (name): <input type="checkbox"/> Location: <input type="checkbox"/> Advertisement:		

## CONFIDENTIAL INSURANCE INFORMATION

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, does patient have dual coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of primary insurance:		Insurance Company Address:			Insurance Co. phone#:
Subscriber's name:	Subscriber's ID (SSN):	Birth date: / /	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber: <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Insurance Company Address:			Insurance Co. phone#:
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber: <input type="checkbox"/> Child <input type="checkbox"/> 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.:
		( )	( )

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 Carlsbad Children's Dentistry and my insurance company to release any information required to process my claims.

Parent/Guardian Signature:	Date:
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