

Lancaster Pediatric Dental Associates



TODAY'S DATE _____ REFERRED BY: _____

PATIENT'S NAME _____ Preferred Name: _____
Last First MI

DATE OF BIRTH ____/____/____ AGE _____ MALE FEMALE

FATHER'S NAME _____ MOTHER'S NAME _____

ADDRESS _____
Number and Street City State Zip

HOME TELEPHONE _____

NAME OF CHILD'S PRIMARY PHYSICIAN _____ TELEPHONE _____

FAMILY DENTIST _____ TELEPHONE _____

FATHER'S EMPLOYER _____ MOTHER'S EMPLOYER _____

FATHER'S WORK NUMBER _____ MOTHER'S WORK NUMBER _____

FATHER'S CELL NUMBER _____ MOTHER'S CELL NUMBER _____

DO WE HAVE YOUR PERMISSION TO CONTACT YOU AT YOUR WORK NUMBER IF NECESSARY? YES NO

BILLING INFORMATION

Responsible Party _____ DATE OF BIRTH ____/____/____

Home Address _____ Home Phone(____) _____

Employer _____ Work Phone(____) _____ Occupation _____

Relationship to Patient _____ Marital Status (circle one): Single Married Divorced Widowed

INSURANCE INFORMATION - PRIMARY

Name of Insured: _____

Dental Insurance _____

Address _____

Group # _____ Phone # _____

Relationship to Patient _____

SSN _____ Insured's DOB ____/____/____

Occupation _____

Marital Status: Single Married Partner Other Divorced Widowed
(circle one)

INSURANCE INFORMATION - SECONDARY

Name of Insured: _____

Dental Insurance _____

Address _____

Group # _____ Phone# _____

Relationship to Patient _____

SSN _____ Insured's DOB ____/____/____

Occupation _____

Marital Status: Single Married Partner Other Divorced Widowed
(circle one)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any dentist, physician, hospital, pharmacy, insurance company, employer or insuring organization to release any information regarding my child's dental history, treatment or benefits payable for this claim for the purpose of validating and determining benefits payable in connection with this claim. This authorization or copy of the original shall be valid for the duration of the patient's relationship with this practice or until the information contained within changes.

AUTHORIZATION TO PAY BENEFITS TO THE DENTIST: I hereby certify to the above statements. I hereby authorize payment directly to the above named dentist of the group benefits otherwise payable to me.

 Parent's Signature

 Date