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**2431 Easton Avenue, Bethlehem, Pa 18017 (610)861-0190**

**1050 S. Cedar Crest Blvd. Suite 104, Allentown, Pa 18103 (610)973-2090**

***CHILD PATIENT INFORMATION***

Patient Name (CHILD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_ F\_\_ Date of birth\_\_\_\_\_\_ Age\_\_\_\_\_\_\_

Child’s Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_St\_\_\_Zip\_\_\_\_\_\_

***PARENT’S INFORMATION* (Who is financially responsible?)**

Parent’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_St\_\_\_Zip\_\_\_\_\_\_\_\_\_

Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_Work#\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_Spouse Social Sec#\_\_\_\_\_\_\_\_\_\_

Spouse Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOW DID YOU FIND US?**

Google\_\_ Office Website\_\_ Insurance Website\_\_ Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Seen\_\_\_\_\_\_\_\_\_\_

Former Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Seen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Dental Insurance Information* Primary Insurance**

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Soc Sec OR ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance** Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID or Soc. Sec. \_\_\_\_\_\_\_\_\_\_\_#Date of Birth\_\_\_\_\_\_\_\_\_

I ACKNOWLEDGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT. I AGREE THAT PARENTS, GUARDIANS OR PERSONAL REPRESENTATIVES ARE RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR TREATMENT OF A MINOR /CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES FOR SERVICES OR ITEMS PROVIDED TO ME, TO MY MINOR/CHILD, OR TO THE PATIENT FOR WHOM I HAVE LEGAL RESPONSIBILITY. I UNDERSTAND THAT FILING A CLAIM WITH MY INSURANCE COMPANY DOES NOT RELIEVE ME FROM MY RESPONSIBILITY FOR THE PAYMENT OF ALL CHARGES.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PROCEED TO NEXT PAGE)