PEDIATRIC DENTAL ASSOCIATES

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RESPONSIBLE PARTY INFORMATION

Name: ______________________________

Address: ______________________ City/State/'Zip ______________________

Mailing Address: ______________________ City/State/'Zip ______________________

How long at this address: __________ Home Phone: __________ Work Phone: __________

Social Security Number: ______________________ Birthday: ______________________

Martial Status: S ☐ M ☐ D ☐ Relationship to Patient: ______________________

Employer: __________ Occupation: __________ No. of years Employed: ______

Spouse's Name: ______________________________

Employer: __________ Occupation: __________ No. of years Employed: ______

Social Security Number: __________ Birthday: __________ Work Phone: __________

DENTAL INSURANCE INFORMATION

Insured's Name: ______________________________

Insured's Social Security Number: ______________________________

Insurance Company: __________ Group No: __________ Phone No. __________

Insurance Company Address: ______________________________

Insured's Employer: ______________________________

Do you have dual coverage? ☐ YES ☐ NO if YES:

Insured's Name: ______________________________

Insured's Social Security Number: ______________________________

Insurance Company: __________ Group No: __________ Phone No. __________

Insurance Company Address: ______________________________

Insured's Employer: ______________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you: ______________________________

Address: ______________________ City/State/'Zip ______________________

Phone: ______________________ Relationship: ______________________

SIGNATURE ______________________________ DATE __________

UPDATES (DATE & INITIAL) ________ ________ ________ ________ ________ ________
CONFIDENTIAL (FOR RECORD AND PRETREATMENT EVALUATION)