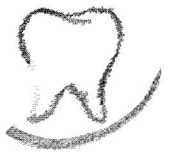
Welcome To Our Office!



Today's Date _____

Child's Name _____ Sex: M F Nickname _____

Age _____ Birthdate _____ Home Phone _____

Child's Address _____

Responsible Party

Mother Social Security No. _____ - ____ - _____

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ State _____ Zip Code _____

Telephone Numbers: Home _____ Office _____ Birthdate _____

Employer Name _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Father Social Security No. _____ - ____ - _____

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ State _____ Zip Code _____

Telephone Numbers: Home _____ Office _____ Birthdate _____

Employer Name _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Parent's Marital Status: (Circle one) Married Divorced Separated Widowed Single

Has Financial Responsibility Been Established By A Court Decree? ❑ Yes ❑ No

If Yes, Person Responsible For Child _____

Emergency Contact: Name _____ Phone _____

Dental Insurance

Primary Insurance Co. _____ I.D. No. _____

Address _____

Policy Holder _____ Relationship To Patient _____

Secondary Insurance Co. _____ I.D. No. _____

Address _____

Policy Holder _____ Relationship To Patient _____

How Did You Hear About Our Office? ❑ Mailing ❑ Yellow Pages ❑ Newspaper ❑ Referral ❑ Other _____

Whom May We Thank For Your Referral _____

By signing this form I agree to assign Thomas J. Madl Jr., D.M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also hereby authorize the use of this signature on all my insurance submissions, manual or electronic, and agree to the release of information necessary to secure benefits.

_____ _____

Signature of Parent or Guardian *Date*