Welcome to

FALES PEDIATRIC DENTISTRY

Tell Us About Your Child	
Child s Name: _____ *Last* *First* *MI*	Whom May We Thank for Referring You?
Child s Birthdate: / / Child s Age_____	For?
Preferred Name:_____ Male Female (Please Circle)	Present/Previous Dentist? (Please Circle)
SS #:	Last Seen for?
School: Grade:	Date of Last X-Rays?
Lives With: Mom/Dad/Grandparent/Foster/Other: _____ (Please Circle)	Have you requested that x-rays be sent to us?
Child s Address: _____ City: _____State: _____ Zip: _____ Child s Home Phone: _____ Email: _____	Other Siblings Seen by us: _____ DOB: _____ _____ DOB: _____ _____ DOB: _____

Parent/Guarantor Information	Parent/Guarantor Information
Marital Status: Married/Single/Divorced/Widowed (Please Circle)	Marital Status: Married/Single/Divorced/Widowed (Please Circle)
Full Name: Relationship to Child:	Full Name: Relationship to Child:
Date of Birth: Home Phone:	Date of Birth: Home Phone:
Work Phone: Cell Phone:	Work Phone: Cell Phone:
Address:_____ City:_____ State: _____ Zip: _____ Email:	Address:_____ City:_____ State:_____ Zip:_____ Email:
SS #:	SS #:
Employer:	Employer:
Employer s Address: _____ _____	Employer s Address: _____ _____

Insurance Coverage	
Policy Holder s Name:	Policy Holder s Name:
Birthdate: SS#:	Birthdate: SS#:
Relationship to Patient:	Relationship to Patient:
Employer:	Employer:
Group/Plan/ID #:	Group/Plan/ID #:
Insurance Co. Name:	Insurance Co. Name:
Insurance Co. Phone #:	Insurance Co. Phone #:

Responsible Parties:

Scheduling Appts: Mother/Father/Grandparent/Foster/Guardian (Please Circle)

Accompanying Child to Appts. Mother/Father/Grandparent/Foster/Guardian (Please Circle)

(Note: Separate authorization form **must be** completed by legal parent/guardian if another person brings child to appointments. Please request one, if needed.)

Assignment of Insurance Benefits:

To the extent permitted under applicable law, I authorize release of my information relating to claims submitted by this dental office. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Fales Pediatric Dentistry, P.A. and/or John T. Fales, Jr., D.D.S., M.S.. I understand this authorization will remain in effect until I specifically request a change in its status. *I agree to be responsible for all charges for dental services and materials not paid by my family s dental benefit plan.*

_____ _____

Signature of Parent/Legal Guardian Date: