

Child's Information

Child's Name: _____ Birth date: _____
Circle: Male Female Child's Social Security Number: _____
Who brought the child in today? _____
If someone referred you, who may we thank? _____

Parents' Information

Father's Name: _____ Mother's Name: _____
Residence: _____ Residence: _____
Mailing Address: _____ Mailing Address: _____
City: _____ City: _____
Home Phone: _____ Home Phone: _____
Birthdate: _____ Birthdate: _____
Social Security: _____ Social Security: _____
Employer: _____ Employer: _____
Address: _____ Address: _____
City: _____ City: _____
Work Phone Number: _____ Work phone Number: _____
Married to child's mother? Yes No or Divorced Married to child's father? Yes No or Divorced

If parents are unmarried or divorced who has custody? _____
If parents are unmarried or divorced who has medical directive to authorize treatment? _____
Additional comments: _____

**If child does not reside with either parent who has legal custody?
Complete below. We will need a court document to be provided to us**

Legal Guardian Name: _____ Employer: _____
Residence: _____ Employer's address: _____
Mailing Address: _____ City: _____
Home Phone: _____ Work Number: _____
Birthdate: _____ Social Security: _____

In case of an emergency

Whom should we notify? _____ Telephone
(someone other than spouse or persons listed above)

Type of pay please circle below

Cash Insurance Medical Migrant Program TCC Tule River Other_____

If you have insurance, please fill out the reverse side of this form.

I THE PARENT OR LEGAL GUARDIAN DECLARE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR TOTAL PAYMENT OF ALL PROCEDURES PERFORMED IN THIS OFFICE AND PROVIDED FOR THE ABOVE NAMED CHILD; REGARDLESS OF INSURANCE COVERAGE.

I ALSO, UNDERSTAND THAT INTEREST AT A RATE OF 1.5% (18% ANNUAL RATE) AND OR LATE CHARGES MAY BE APPLIED. ANY LEGAL FEES OR REASONABLE CHARGES REQUIRED TO COLLECT AN UNPAID BALANCE WILL ALSO BE MY RESPONSIBILITY. THE UNDERSIGNED CONSENTS TO AND AUTHORIZES THE RELEASE OF INFORMATION CONTAINED ON THIS FORM OR A COPY, IN ADDITION TO BILLING INFORMATION, FEES, AND COST, FOR DENTAL SERVICES PROVIDED ON THE ABOVE NAMED CHILD TO THE FOLLOWING INDIVIDUALS FATHER OR MOTHER OF CHILD, AN ATTORNEY OR COLLECTION AGENCY.

I ALSO HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DENTAL ENTITY GEORGE M. WILSON D.D.S., INC.

SIGNATURE: _____ DATE: _____

Child's name: _____ **Date of Birth:** _____

The primary plan is determined by birth month. For example: 1 birth month is May and the other birth month is August; the insured whose birth-date is in May is prime.

Section 1: Date: _____

Primary Insurance: _____

Address: _____

Effective date? _____

Group or Plan Number: _____

Covered employee: _____

Relationship to patient? _____

Secondary Insurance: _____

Address: _____

Effective date? _____

Group or Plan Number: _____

Covered employee: _____

Relationship to patient? _____

If parents or legal guardians are divorced or do not live together, then who has physical custody 51% or more of the time? _____ (This is exception to the birth-date rule. Prime would be whoever has custody 51% of the time.)

If there is a court order stating a certain person should be prime we will need a copy of it.

Section 2: Date: _____

Primary Insurance: _____

Address: _____

Effective date? _____

Group or Plan Number: _____

Covered employee: _____

Relationship to patient? _____

Secondary Insurance: _____

Address: _____

Effective date? _____

Group or Plan Number: _____

Covered employee: _____

Relationship to patient? _____

If parents or legal guardians are divorced or do not live together, then who has physical custody 51% or more of the time? _____ (This is exception to the birth-date rule. Prime would be whoever has custody 51% of the time.)

If there is a court order stating a certain person should be prime we will need a copy of it.

Section 3: Date: _____

Primary Insurance: _____

Address: _____

Effective date? _____

Group or Plan Number: _____

Covered employee: _____

Relationship to patient? _____

Secondary Insurance: _____

Address: _____

Effective date? _____

Group or Plan Number: _____

Covered employee: _____

Relationship to patient? _____

If parents or legal guardians are divorced or do not live together, then who has physical custody 51% or more of the time? _____ (This is exception to the birth-date rule. Prime would be whoever has custody 51% of the time.)

If there is a court order stating a certain person should be prime we will need a copy of it.