



Welcome

www.excellenceindentistry.com

Your dental health and happiness are the primary goals for our team. Please accurately complete this confidential form to help these goals become a reality for you!



About Your Child

Today's Date: _____

Child's Name: _____

Last

First

Middle Initial

☐ Male ☐ Female Child prefers to be called: _____

Birth Date: ____/____/____ SS #: _____

Home Address: _____

City

State

Zip

Home Telephone #: _____

Previous/Present Dentist: _____

(please circle)

Date of Last Dental Visit: _____



Parent/Guardian Info

Father's Full Name: _____

Address (if different from child's): _____

City

State

Zip

Home Telephone #: _____

Birth Date: ____/____/____ SS #: _____

Employer: _____

Occupation: _____ How Long Held: _____

Best Time/Place to Reach: _____

Mother's Full Name: _____

Address (if different from child's): _____

City

State

Zip

Home Telephone #: _____

Birth Date: ____/____/____ SS #: _____

Employer: _____

Occupation: _____ How Long Held: _____

Best Time/Place to Reach: _____



Referral Information

Are other family members currently seen in our office?

☐ No ☐ Yes location: _____

name of account holder: _____

How did you hear about our office?

☐ Family/Friends/Co-Workers name: _____

☐ Internet website: _____

☐ Angie's List ☐ Google Places ☐ Mynewsmile ☐ Website Search

☐ Direct Mail Piece

☐ Newspaper Advertisement ☐ Television ☐ Magazine

☐ Insurance Plan name: _____

☐ Other explain: _____



Primary Dental Insurance

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ____/____/____ ID/SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ____/____/____ ID/SS #: _____

Insured's Employer: _____



Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for my child's proper dental care.

I consent to the dentist's use and disclosure of my child's records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my child's records to the following persons who are involved in my child's care or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my child's dental care insurance carrier or payor of dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my child's dental care payor. I attest to the accuracy of the information on this page.

Parent's or Guardian's Signature

Date

OVER →