WELCOME

PATIENT INFORMATION DATE_____________

CHILD'S LAST NAME_____________________________FIRST___________________MIDDLE__________

ADDRESS_________________________________CITY_____________STATE__________ZIP__________
_

PHONE_____________BIRTHDATE__________MALE____FEMALE____SCHOOL___________________

HOW DID YOU HEAR ABOUT OUR OFFICE?____

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME____MARITAL STATUS____________

MAILING ADDRESS___________________________CITY______________STATE______ZIP__________

HOME PHONE____________________________________WORK PHONE__________________________

SOCIAL SECURITY #___________________________________BIRTHDATE________________________

EMPLOYER_____________________________________OCCUPATION____________________________

MOTHER'S NAME____MARITAL STATUS___________

MAILING ADDRESS___________________CITY____________________STATE_____ZIP____________

HOME PHONE_____________________________________WORK PHONE________________________

SOCIAL SECURITY #__________________________________BIRTHDATE_________________________

EMPLOYER______________________________________OCCUPATION___________________________

WHO IS FINANCIALLY RESPONSIBLE FOR THE CHILD?______________________________________

EMERGENCY CONTACT________________________________RELATIONSHIP____________________

ADDRESS____PHONE #________________

PLEASE COMPLETE OTHER SIDE

MINOR CHILD TREATMENT RELEASE

I GIVE MY PERMISSION TO DR. STEVEN P. ELLINWOOD AND/OR HIS DESIGNATED ASSISTANT TO PERFORM ANY AND ALL DENTAL TECHNIQUES AND PROCEDURES, INCLUDING BUT NOT LIMITED TO THE ADMINISTRATION OF NITROUS OXIDE SEDATION AND ANESTHETICS, ON MY CHILD ____, WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED. I FURTHER EXPRESSLY AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL TREATMENT RENDERED TO THE ABOVE-NAMED CHILD AS OUTLINED IN THE FINANCIAL POLICY AGREEMENT.

SIGNED____DATE__________________________

RELATIONSHIP TO CHILD____

DENTAL INSURANCE INFORMATION

INSURED'S NAME______________________________________INSURED'S SOC. SEC. #____________

PRIMARY INSURANCE COMPANY__________________________________GROUP #______________

INSURANCE CO. ADDRESS____

SECONDARY INSURANCE CO.__________________________________GROUP #________________

SECONDARY INSURANCE CO. ADDRESS____

SUBSCRIBER'S NAME____BIRTHDATE____________

INSURED'S SOC. SEC. #_______________________________RELATIONSHIP TO PATIENT_________

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY DENTIST TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I, _____________________________________(NAME OF INSURED), HEREBY AUTHORIZE
MY PRESENT INSURANCE COMPANY TO PAY AND HEREBY ASSIGN DIRECTLY TO DR. STEVEN P. ELLINWOOD ALL DENTAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES AS DESCRIBED ON THE ATTACHED FORMS.
AUTHORIZATION IS HEREBY GIVEN TO RELEASE ALL INFORMATION NECESSARY TO THE PAYMENT OF SAID BENEFITS.

AUTHORIZED SIGNATURE____DATE______________