



# NEW PATIENT INFORMATION (child) (Please use blue or black ink)

## PLEASE COMPLETE ALL BOXES

Name:		Nickname:	Date of birth:
Address:		City:	Zip
Primary phone:		Secondary phone:	
Age:	Sex: M F	School:	Grade:

Dentist:		Date of last cleaning:
Physician:		Date of last exam:
Taking medication? <input type="checkbox"/> yes <input type="checkbox"/> no	What?	
Serious or recurrent illness? <input type="checkbox"/> yes <input type="checkbox"/> no	What?	
Allergic to latex? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you take antibiotics for dental appointments? <input type="checkbox"/> yes <input type="checkbox"/> no	
Who may we thank for referring you to our office?		

Parents (or custodial parent):		
Address:	City:	Zip:
Primary phone:	Email:	
Cell phones (whose?):		
Marital Status ( <i>circle which</i> ): <i>married single divorced separated widowed</i>		

Have we seen any other members of your family? <input type="checkbox"/> yes <input type="checkbox"/> no	Who?
What are your main concerns with your son's/daughter's teeth or bite?	

**If I (parent, guardian, custodial parent – circle which) cannot accompany my child to the initial consultation or any other appointment, I give my permission for Dr. Crock or his staff to treat my child.**

Parent's signature:	Child's name:
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 FOR OFFICE USE ONLY

Appointment \_\_\_\_\_ with

**Please read and sign both sides**

# RESPONSIBLE PARTY, EMPLOYMENT, AND INSURANCE INFORMATION

**\*Please list ALL parent/step-parent information, regardless if there is no insurance coverage\***

Parent/Guardian

Name:		Relationship to patient:	
Address:		Cell phone:	
Date of birth:		Social security #	
Employer:	How long there?	Work phone:	
Dental insurance company:		Orthodontic benefit:	

Primary or secondary? *(circle which)*

Parent/Guardian

Name:		Relationship to patient:	
Address:		Cell phone:	
Date of birth:		Social security #	
Employer:	How long there?	Work phone:	
Dental insurance company:		Orthodontic benefit:	

Primary or secondary? *(circle which)*

Parent/Guardian

Name:		Relationship to patient:	
Address:		Cell phone:	
Date of birth:		Social security #	
Employer:	How long there?	Work phone:	
Dental insurance company:		Orthodontic benefit:	

Primary or secondary? *(circle which)*

Parent/Guardian

Name:		Relationship to patient:	
Address:		Cell phone:	
Date of birth:		Social security #	
Employer:	How long there?	Work phone:	
Dental insurance company:		Orthodontic benefit:	

Primary or secondary? *(circle which)*

Patients Name \_\_\_\_\_

**Insurance Authorization**

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Crock Orthodontics to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Crock Orthodontics. I permit a copy of this authorization to be used in place of the original. I give Crock Orthodontics, it's employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance or payment.

Signature: \_\_\_\_\_

The above information is correct and I understand that, where appropriate, credit reports may be obtained.

**Payment Policy**

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance claim forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibly.

Signature: \_\_\_\_\_