NEW PATIENT INFORMATION-CHILD (Please use blue or black ink)

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? ☐ yes ☐ no	What?
Serious or recurrent illness? ☐ yes ☐ no	What?
Allergic to latex? ☐ yes ☐ no	Do you take antibiotics for dental appointments? ☐ yes ☐ 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 *(circle which)*: *married* *single* *divorced* *separated* *widowed*		

Have we seen any other members of your family? ☐ yes ☐ 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:

* *

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 of 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)*

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, its 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.

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 responsibility.

Signature:

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

Signature *(parent's signature if minor)*: