Welcome to Dr. Melanie Richards's Pediatric Dental Office

Patient's Name ___________________________________ Date _____/_____/______ ☐ Male ☐ Female
Last First MI

Patient's Social Security Number___________________ Age_______________ Date of Birth___/____/____

Patient's Nickname______________________________
Residence- Street Address__________________________
City____________________ State_____ Zip__________

Father/Guardian's Legal Name
Name____
Last First MI
Address_______________________________________
City_______________State___________Zip_________
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Home ( )_______________ Cell ( )_______________
Employed by______________ Work ( )_____________
Email__________________ Date of Birth___/____/____
Social Security Number___________________________
Drivers License Number__________________________

Mother/Guardian's Legal Name
Name____
Last First MI
Address_______________________________________
City_______________State___________Zip_________
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Home ( )______________ Cell ( )_________________
Employed by______________ Work ( )_____________
Email__________________ Date of Birth___/____/____
Social Security Number___________________________
Drivers License Number__________________________

Purpose of appointment___________________________

Who may we thank for this referral__________________

Someone to notify in case of emergency <u>not</u> living with you:
Name______________________ Phone______________
Relationship to Patient_____________________________

Dental Insurance Information
Employee Name____________________________
Date of Birth______________________________
Relationship to Patient______________________
Employer Name____________________________

Name of Insurance Co______________________
Address_____________________________________
____
Telephone___________________________________
Alternate ID_______________Group #_________
Social Security Number_____________________

Consent:
I consent to the diagnostic procedures and treatment by the dentist necessary for the 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 dental care insurance carrier or payor of my 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 dental care payor.
I attest to the accuracy of the information on this page.
___________________________ ___________
Parent/Legal Guardian's Signature Date

Acknowledgement of Receipt of Privacy Practices Notice

I, ____________________________, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

___________________________________ ______________________
Signature Date

I give the above named office my permission to leave phone messages regarding appointments, treatment needs, monies owed, etc. on the following phone numbers:

☐ Home______________________ ☐ Work______________________ ☐ Cell _____________________ ☐ Other___________________________

__________________________________ ______________________
Signature Date