New Patient Information

CHILD'S INFORMATION
Child's name ____
Nickname ____
Child's SSN ____
Date of birth ____
Age ____
Gender ____
Home address ____
City ____
State ____
Zip code ____
Child's school/daycare ______________________________________
Who brought the child today?__________________________________
Are you the child's guardian?__________________________________

CAREGIVER INFORMATION
Name ______________________
Relation to child?______________________
Legal guardian?______________________
SSN______________________
Address______________________
City______________________
State ______________________
Zip______________________
Employer ______________________
Occupation ______________________
Contact Phone #______________________
Email______________________
How would you like to receive notifications?
phone text email

CAREGIVER INFORMATION
Name ______________________
Relation to child?______________________
Legal guardian?______________________
SSN______________________
Address______________________
City______________________
State ______________________
Zip______________________
Employer ______________________
Occupation ______________________
Contact Phone #______________________
Email______________________
How would you like to receive notifications?
phone text email

DENTAL INSURANCE (If you have your insurance card with you, skip this section. We can make a copy of your card instead.)
Insurance company ______________________________________
Address ______________________________________
Insurance phone # ______________________________________
Group # ______________________________________
ID # ______________________________________
Policy owner's name ______________________________________
Policy owner's relation to patient ______________________________
Policy owner's DOB ______________________________
Policy owner's SSN ______________________________
Policy owner's employer ______________________________

Child's name ___________________

Whom may we thank for referring you to our practice?

- ❑ Another patient, friend
- ❑ Pediatrician
- ❑ Another patient, relative
- ❑ Dental Office
- ❑ Internet
- ❑ School
- ❑ Work
- ❑ Other _____________

Name of person or office referring you to our practice: ____

Authorization for Release of Health Information
I authorize Cardinal Pediatric Dentistry to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my (child's) medical history, or services rendered or treatment given to my child/children that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or a similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

Authorization for Submission of Claims and Assignment of Benefits
I authorize Cardinal Pediatric Dentistry to submit claims for payment of services to insurance companies or healthcare service plans that provide coverage for the patient, on my behalf and in my name, and assign insurance benefits otherwise payable to me to Cardinal Pediatric Dentistry, but not to exceed the provider's actual charges for covered services. This authorization shall remain effective for any services rendered to the patient by Cardinal Pediatric Dentistry. I know I have a right to receive a copy of this authorization if requested. I also understand that it is my responsibility to know and understand my benefits, limitations, and exclusions of my individual policy.

Because the patient is a minor, it is necessary that signed permission be obtained from a parent or guardian before dental care can be rendered. As the person bringing the child to the visit I am acting as his/her guardian at this time. I authorize the team at Cardinal Pediatric Dentistry to perform appropriate preventative and therapeutic dental services for this child in accordance with accepted standards of pediatric dental care. The information I have given is correct to the best of my knowledge, I understand that it will be held in strict confidence, and it is my responsibility to inform the office of any changes in the child's medical status moving forward.

Guardian's name ____

Guardian's Signature ____

Date ____