PEDIATRIC DENTISTRY OF NEWNAN

Dr. Kim Mathews

Welcome to our office! Please carefully COMPLETE this form so that we may better serve you. If you have any questions we will be happy to assist you. We look forward to helping you maintain your child's dental health.

CHILD INFORMATION

Date_____DOB_____Sex_____F____M

Full Name_____

Preferred Name_____

Address_____

City_____ State_____Zip_____

Home Phone_____Cell_____

Email_____

School_____ Grade_____

Who can we thank for referring you?_____

SOCIAL MEDIA/COMMUNICATIONS

So that our friends can like and share in your child's experience at our office, do we have your permission to use your child's/children's picture on our facebook page?

_____Yes _____No

* I understand the confidentiality of electronic communications (e-mail, text, ect.) cannot be guaranteed and Pediatric Dentistry of Newnan is not responsible for the confidentiality or security of any message sent to or by me. If any of my contact information changes or at any time I wish to terminate this consent, I agree to notify Pediatric Dentistry of Newnan in writing or in person.

I authorize Pediatric Dentistry of Newnan to contact me via electronic media.

_____/_____

Parent/Guardian Name (Print) Parent/Guardian Name (Signature)

RESPONSIBLE PARTY

Who is responsible for this account?_____

Relationship to patient_____

_____/_____

Parent/Guardian Name (Print) Parent/Guardian Name (Signature)

Insurance Co._____

Phone #_____Group#_____

Member ID#_____

Employer_____

Subscriber Name_____

DOB_____ SS#_____

ASSIGNMENT & RELEASE: I certify that my dependent(s) is covered by insurance with company_____ and I assign directly to Pediatric Dentistry of Newnan all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Pediatric Dentistry of Newnan may use and disclose my child's health care information to the above named insurance company and their agents for the purpose of obtaining payment of services and determining benefits or the benefits for related services. This assignment will remain in effect until I cancel it in writing. I have also read a copy of Pediatric Dentistry of Newnan's Notice of Privacy Practices and I am aware that I am entitled to a copy upon request.

_____/_____

Parent/Guardian Name (Print) Parent/Guardian Name (Signature)

PARENT/GUARDIAN INFORMATION

( ) Mother ( ) Father ( ) Guardian ( ) Step Mother ( ) Step Father ( ) Other_____

Name_____ DOB_____ Employer_____

Address_____

Home Phone_____ Cell_____Work_____Ext._____

( ) Mother ( ) Father ( ) Guardian ( ) Step Mother ( ) Step Father ( ) Other_____

Name_____ DOB_____ Employer_____

Address_____

Home Phone_____ Cell_____Work_____Ext._____

(Over)