timberwood park
PEDIATRIC DENTISTRY

PATIENT INFORMATION

Your Child/Children

Name: _____ Name: _____

Name: _____ Name: _____

Parent Information (Circle One): Mother Stepmother Father Stepfather Guardian
(circle one) Married Divorced Single

Name: _____ Birthdate: _____
Occupation: _____ SS#: _____
Primary phone #: _____ Secondary #: _____
Email Address: _____
Address:_____ City:_____ State:_____ Zip Code:_____

Parent Information (Circle One): Mother Stepmother Father Stepfather Guardian
(circle one) Married Divorced Single

Name: _____ Birthdate: _____
Occupation: _____ SS#: _____
Primary phone #: _____ Secondary #: _____
Email Address: _____
Address:_____ City:_____ State:_____ Zip Code:_____

Who is responsible for making appointments? _____
How did you find us? _____

Primary Dental Insurance

Subscribers Name: _____ Relationship to child: _____
Birthdate:_____ SS#:_____
Employer Address:_____Occupation:_____
Insurance Company: _____ID #: _____Group#:_____
Insurance Company Address: _____

Additional Insurance

Subscribers Name:_____Relationship to child: _____
Birthdate:_____ SS#:_____
Employer Address:_____Occupation:_____
Insurance Company: _____ID #: _____Group#:_____
Insurance Company Address: _____

Authorization and Release: ***I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to the third-party payers and/or other health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents.***

Signature of Parent or Legal Guardian: _____ Date: _____

For your convenience, we offer the following methods of payment: cash, personal check, or credit card. Payment is due in full at each appointment.