

## Welcome

We are pleased to welcome you and your child to our practice. Our goal is to educate, motivate, and promote good oral health that will last a lifetime. Please take a few minutes to fill out this form completely. Please mark "SAME" or "N/A" where appropriate.

Child's Name:		Nickname:	Male / Female
Home Address:			
Phone: ()	SSN:	Child's Birthdate:/	/ Age:
School:	Grade:	Special interests/ Pets:	
2. Person Accor	mpanying The Child		
Name:		Relation to child	d:
Address:			
Phone: ()	Work #: () _	Ext: Cell #: (	_)
Are you the legal guardian	of this child? Yes / No	Are you the person responsible for the	ne account? Yes / No
If no, please name the l	legal guardian / responsible party	:	
_		:	
How did you hear about us'  3. Parent's Infor	rmation Marital Sta	Whom may we thank for referring you:	Separated Widowed
How did you hear about us'  3. Parent's Infor  Mother  Name:	rmation Marital Sta	Whom may we thank for referring you:	Separated Widowed
3. Parent's Infor Mother Name:	*Warital Sta	Whom may we thank for referring you:	Separated Widowed
How did you hear about us'  3. Parent's Infor  Mother  Name: Phone: ()  Employer:	*Warital Sta	tus: Married Single Divorced  Birthdate:/ SSN: Email:	Separated Widowed
3. Parent's Infor Mother Name: Phone: () Employer: Father	*Warital Sta *  Marital Sta	tus: Married Single Divorced  Birthdate:/ SSN: Email:	Separated Widowed
3. Parent's Infor  Mother  Name:  Employer:  Father  Name:	*Warital Sta  Marital Sta  Wk#:()  Occupation:	tus: Married Single Divorced  Birthdate:/ SSN: Email: DL#:	Separated Widowed



Date of last dental visit:	Why did you bring your chi	ild to the dentist today?			·
5. Child's Medical History  Has your child ever had the following medical problems? Please circle Y or N  Y N Asthma Y N Behavioral problems Y N Diabetes Y N HIV/AIDS  Y N Heart Murmurs Y N Cancer Y N Hepatitis Y N Nervous disord  Y N Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/Disability Y N Rheumatic Fe  Y N ADD/ADHD Y N Convulsions/Epilepsy Y N Hearing Impairments Y N Speech delays  Y N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis C  Please discuss any medical problems that your child has had:  Child's physician: Phone #: Develop./ Least Visit: Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals  Other: Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Is your child having dental pr	roblems at this time? If so, explain	-		
Is your child's drinking water fluoridated? Yes / No Is your child taking fluoride supplements? Yes / No How often do your child's teeth get brushed? How often do they get flossed? How often do your child's teeth get brushed? How often do they get flossed? Does your child have any of the following dental habits? Please circle Yor N Y N Thumb/ finger sucking Y N Nursing/ bottle habits Y N Bites/ chews objects Y N Mouth breather Y N Facifier Y N Grinds/ clenches teeth Y N Tongue thrusting Y N Pain in jaw (TI  5. Child's Medical History  Has your child ever had the following medical problems? Please circle Y or N Y N Asthma Y N Behavioral problems Y N Diabetes Y N Hepatitis Y N Nervous disord Y N Heart Murmurs Y N Cancer Y N Hepatitis Y N Nervous disord Y N Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/ Disability Y N Returnatic Fe Y N ADD/ADHD Y N Convulsions/ Epilepsy Y N Hearing Impairments Y N Speech delays Y N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (**  Please discuss any medical problems that your child has had:  Child's physician: Phone #: Last Visit: Please list any drugs your child is currently taking:  Please list any drugs your child is currently taking:  Please list any drugs your child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Has your child had any unfav	vorable dental experiences? If so, e	explain		
How often do your child's teeth get brushed?  Does your child have any of the following dental habits? Please circle Y or N  N Thumb' finger sucking N N Description N Pacifier N Pain in jaw (TI N Pain in	Date of last dental visit:	Pr	evious dentis	et's name:	
Does your child have any of the following dental habits? Please circle Y or N Y N Thumb/ finger sucking Y N Nursing/ bottle habits Y N Bites/ chews objects Y N Mouth breather Y N Pacifier Y N Grinds/ clenches teeth Y N Tongue thrusting Y N Pain in jaw (T)  5. Child's Medical History  Has your child ever had the following medical problems? Please circle Y or N Y N Asthma Y N Behavioral problems Y N Diabetes Y N HilV/AIDS Y N Heart Murmurs Y N Cancer Y N Hepatitis Y N Nervous disore Y N Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/ Disability Y N Rheumatic Fe Y N ADD/ADHD Y N Convulsions / Epilepsy Y N Hearing Impairments Y N Speech delays Y N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (**  Please discuss any medical problems that your child has had:  Child's physician: Phone #: ( ) Last Visit: Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals  Other: Other: Other: I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Is your child's drinking water	r fluoridated? Yes / No Is	your child ta	aking fluoride supplemen	nts? Yes / No
Y N Thumb/ finger sucking Y N Darinds/ clenches teeth Y N Tongue thrusting Y N Pain in jaw (TI Y N Pacifier Y N Grinds/ clenches teeth Y N Tongue thrusting Y N Pain in jaw (TI Y N N Pain in jaw (Ti N N N Pain in jaw (Ti N N N Pain in jaw (Ti N N N N Pain i	How often do your child's tee	eth get brushed?	Но	w often do they get floss	sed?
5. Child's Medical History  Has your child ever had the following medical problems? Please circle Y or N  Y N Asthma Y N Behavioral problems Y N Diabetes Y N HIV/AIDS Y N Heart Murmurs Y N Cancer Y N Hepatitis Y N Nervous disorc Y N Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/ Disability Y N Rheumatic Fe Y N ADD/ADHD Y N Convulsions / Epilepsy Y N Hearing Impairments Y N Speech delays Y N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (Congenital Heart Defect Y N Handicaps/ Disability Y N Tuberculosis (Congenital Heart Defect Y N Handicaps/ Disability Y N Tuberculosis (Congenital Heart Defect Y N Handicaps/ Disability Y N Tuberculosis (Congenital Heart Defect Y N Hemophilia Y N Tuberculosis (Congenital Stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (Congenital Stays Y N Hemophilia Y N Tuberculosis (Congenital Heart Y N Hemophilia Y N Tuberculosis (Congenital Hemophilia Y N Hemophilia Y N Tuberculosis (Congenital Hemophilia Y N Hemo	Does your child have any of	f the following dental habits? Plea	se circle Y	or N	
5. Child's Medical History  Has your child ever had the following medical problems? Please circle Y or N  Y N Asthma Y N Behavioral problems Y N Diabetes Y N HIV/AIDS  Y N Heart Murmurs Y N Cancer Y N Hepatitis Y N Nervous disord  Y N Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/ Disability Y N Rheumatic Fe  Y N ADD/ADHD Y N Convulsions/ Epilepsy Y N Hearing Impairments Y N Speech delays  Y N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (  Please discuss any medical problems that your child has had:  Child's physician: Phone #: Develop./ Learning delays Y N Hemophilia Phone #: Develop./ N Hemophilia Phone #:				· ·	
Has your child ever had the following medical problems? Please circle Y or N  Y N Asthma Y N Behavioral problems Y N Diabetes Y N HIV / AIDS Y N Heart Murmurs Y N Cancer Y N Hepatitis Y N Nervous disord Y N Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/ Disability Y N Rheumatic Fe Y N ADD/ ADHD Y N Convulsions / Epilepsy Y N Hearing Impairments Y N Speech delays Y N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (Consent for Treatment)  Child's physician:  Phone #: () Last Visit:  Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Y N Pacifier	Y N Grinds/ clenches teetl	h <mark>Y</mark> N	Tongue thrusting	Y N Pain in jaw (TM
Has your child ever had the following medical problems? Please circle Y or N  Y N Asthma Y N Behavioral problems Y N Diabetes Y N Heyatitis Y N Nervous disord Y N Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/Disability Y N Rheumatic Fe Y N ADD/ADHD Y N Convulsions/Epilepsy Y N Hearing Impairments Y N Speech delays Y N Any hospital stays Y N Develop/ Learning delays Y N Hemophilia Y N Tuberculosis (  Please discuss any medical problems that your child has had:  Child's physician:  Phone #: () Last Visit:  Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.					
Y N Asthma Y N Behavioral problems Y N Diabetes Y N HIV/AIDS Y N Heart Murmurs Y N Cancer Y N Hepatitis Y N N Nervous disord Y N Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/ Disability Y N Rheumatic Fe Y N ADD/ADHD Y N Convulsions / Epilepsy Y N Hearing Impairments Y N Speech delays Y N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (1)  Please discuss any medical problems that your child has had:  Child's physician: Phone #: () Last Visit:  Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals  Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.		_			
N Heart Murmurs  Y N Cancer  Y N Hepatitis  Y N Nervous disord  Y N Abnormal Bleeding  Y N Congenital Heart Defect  Y N Handicaps/ Disability  Y N Rheumatic Fe  Y N Hearing Impairments  Y N Speech delays  N Any hospital stays  Y N Develop./ Learning delays  Y N Hemophilia  Y N Tuberculosis  Please discuss any medical problems that your child has had:  Please list any drugs your child is currently taking:  Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals  Other:  1 attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	•	2			
A Abnormal Bleeding Y N Congenital Heart Defect Y N Handicaps/ Disability Y N Rheumatic Fe N ADD/ADHD Y N Convulsions / Epilepsy Y N Hearing Impairments Y N Speech delays N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (1)  Please discuss any medical problems that your child has had:  Child's physician:Phone #: () Last Visit:  Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals  Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.		•			
(N ADD/ADHD Y N Convulsions / Epilepsy Y N Hearing Impairments Y N Speech delays N Any hospital stays Y N Develop./ Learning delays Y N Hemophilia Y N Tuberculosis (1)  Please discuss any medical problems that your child has had:  Child's physician: Phone #: () Last Visit:  Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understart that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.				_	Y N Nervous disorde
Please discuss any medical problems that your child has had:  Child's physician: Phone #: () Last Visit:  Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.		•			
Please discuss any medical problems that your child has had:  Child's physician:Phone #: ()Last Visit:  Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals  Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Y N ADD/ADHD	Y N Convulsions / Epilepsy	Y N	Hearing Impairments	Y N Speech delays
Child's physician:Phone #: ()Last Visit:Please list any drugs your child is currently taking:Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals Other:	N Any hospital stays	Y N Develop./ Learning delay	ys Y N	Hemophilia	Y N Tuberculosis (T
Please list any drugs your child is currently taking:  Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals  Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Please discuss any medical p	problems that your child has had:			
Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals  Other:  6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Child's physician:	Phone #: (_	)	Last Visit:	:
6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Please list any drugs your cl	hild is currently taking:			
6. Consent for Treatment  I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understar that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Please list any drugs / mater	rials that your child is allergic to:	penicillin	latex anesthetics	codeine metals
I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understant that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	Other:				
I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understant that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.					
I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understant that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.					
I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understant that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.					
I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understart that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	6. Consent for	Treatment			
office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understart that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.	I attact that the information	- 4h -4 T h	1 t . £ 1-		ihilittimfthi-
staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understart that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.		•	•		•
that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.			•	•	•
demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.				•	
	•		-		
Signature of parent or quardien	demonstration of procedures	and instruments, and variable voice	e tone to aid i	in cooperation during de	ntal treatment.
Signature of parent or quardien					
	=			<del></del>	

Г

## **7.** Payment Information Please read the following:

**Patient's portion of payment is due at the time of service.** We will gladly submit your insurance claim for you; however, we do require any deductibles, co-payments, and "estimated" patient portions be paid at the time of service.

We accept cash, checks, Debit cards, Visa, and MasterCard.

Unpaid balances over 60 days will accrue a **monthly fee** equal to 18% APR. Balances over 90 days will be turned over to a collection **agency**; In this event, **you will be responsible for all collection and legal fees.** 

If a check is returned NSF, there will be a \$25.00 check return fee; from that point on, checks will not be accepted. A missed appointment charge of \$50.00 might be applied to your account if less than 24 hour notice is given.

Policy Holder's Name:		Birthdate:/ SS#:
Insurance Name:		Ins. Phone: ()
Ins. Address:		
		Policy Holder's Employer:
Secondary Insurance ( if app	plicable)	
Policy Holder's Name:		Birthdate:/ SS#:
Insurance Name:		Ins. Phone: ()
Ins. Address:		
Policy ID#:	Group #:	Policy Holder's Employer:

## 9. Authorization and Release

I authorize Young Kidz Dental to submit insurance claims on my behalf. I agree to be responsible for payment of all services rendered on behalf of my dependent. I understand that my dental insurance plan is designed to only **share** in my dental costs, usually covering **50 to 80%** of the total dental bill. I understand the amount of dental benefits I receive is determined by my employer or my insurance company, **not by us.** I understand some dental services may **not** be covered by my insurance plan. I understand it is my responsibility to review my insurance policy and to understand my specific dental benefits. In the event my insurance company has not paid their portion within 60 days, the **balance of the bill will become my responsibility.** I have read and agree to the payment information and release listed above.

Signature of parent or guardian	Date



I give consent for the	e Use and Disclosure of Health Information of myself or my dependant for the purposes of
	or Communication between other healthcare professionals.
	e been provided with a copy of this office's <i>Notice of Privacy Practices</i> that provides a more of health information uses and disclosures.
I understand that I have condensed form.	ve the right to review a copy of this office's Notice of Privacy Practices prior to signing this
Please Print Name	
Signature of parent of	or guardian
Date	
	THANK YOU
	For Office Use Only
	For Office Use Only
	For Office Use Only  a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement
	For Office Use Only  a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement
ould not be obtained l	For Office Use Only  a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement
ould not be obtained l	For Office Use Only  In written acknowledgement of receipt of our <i>Notice of Privacy Practices</i> , but acknowledgement because:
ould not be obtained l	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In the communication barriers prohibited obtaining acknowledgement
ould not be obtained l Individual i An emerge	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because it is a supplied to the properties of the prope
ould not be obtained l Individual i An emerger	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In the communication barriers prohibited obtaining acknowledgement
ould not be obtained legional individual in the control of the con	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because it is a supplied to the property of
could not be obtained by Individual not be obtained by An emerged ansurance Name: insurance Contact:	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In refused to sign Communication barriers prohibited obtaining acknowledgement ency situation prevented us from obtaining acknowledgment Other  Calendar Year?: Y / N Date Verified:
ould not be obtained by Individual not be obtained by An emerged ansurance Name: beductible:%/	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In refused to sign Communication barriers prohibited obtaining acknowledgement ency situation prevented us from obtaining acknowledgment Other  Calendar Year?: Y / N Date Verified:  Phone: Eff Date:  [Child/ Family) Cleaning Sched: FL: BW:
Individual 1 Individual 1 An emerger Insurance Name: Insurance Contact: Deductible:%/	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In refused to sign Communication barriers prohibited obtaining acknowledgement ency situation prevented us from obtaining acknowledgment Other  Calendar Year?: Y / N Date Verified: Phone: Eff Date:
Individual not be obtained la Individual not be obtained la An emerger nsurance Name: nsurance Contact: / Preventive: % Gealants: %	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In Communication barriers prohibited obtaining acknowledgement oncy situation prevented us from obtaining acknowledgment Other  Calendar Year?: Y / N Date Verified:  Phone: Eff Date:  (Child/ Family) Cleaning Sched: FL: BW:  Ded Applies? Y / N Basic: % Major: % Yrly Max:
Individual not be obtained in the could not b	For Office Use Only  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement because:  In communication barriers prohibited obtaining acknowledgement oncy situation prevented us from obtaining acknowledgment Other  Calendar Year?: Y / N Date Verified:  Phone: Eff Date:  [Child/ Family) Cleaning Sched: FL: BW:  Ded Applies? Y / N Major: % Yrly Max:  Post. Comp?: Y / N % Pano / Full Mouth: