

PATIENT INFORMATION

Mother's Name _____ Soc. Sec. # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work # _____

Employer _____ Occupation _____

Father's Name _____ Soc. Sec. # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work # _____

Employer _____ Occupation _____

Legal Guardian Name (if applicable) _____ Soc. Sec. # _____

Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work # _____

Employer _____ Occupation _____

Patient information can be disclosed with: _____

PRIMARY INSURANCE

Subscriber _____

Soc. Sec. # _____

Insurance Co. Name _____

Group # _____

SECONDARY INSURANCE (if applicable)

Subscriber _____

Soc. Sec. # _____

Insurance Co. Name _____

Group # _____

As a courtesy to you we will be happy to bill your dental insurance for you provided you have completed this form.

Office Policy: We strive to stay on schedule. As a courtesy to our patients, we will gladly reschedule appointments with 24 hours notice. If you show up more than ten minutes late, your appointment will be cancelled and rescheduled at your convenience. If you do not show up for a scheduled appointment and do not give prior notice, a written warning will be mailed to your home. If an appointment is missed without prior notice a second time, a \$50.00 charge will apply in order to reschedule the next appointment. If an appointment is missed for a third time, a \$50.00 charge will apply and the patient will be dismissed from the practice.

I have read the above office policy and agree to its terms. In addition, I hereby authorize my insurance benefits to be paid directly to Yakima Pediatric Dentistry. I understand I am financially responsible for non-covered services, as well as any remaining balance after my insurance company has paid. The above information is correct according to my knowledge.

Legally Responsible Person _____ Date: _____