

Welcome to Dr. Melanie Blanton's Pediatric Dental Office

Patient's Name _____ Date of Birth ____/____/____ Male Female
Last MI First

Patient's Social Security Number _____ Age _____ Date _____

Patient's Nickname _____

Residence- Street Address _____

City _____ State _____ Zip _____

Father/Guardian's Legal Name

Name _____

Last MI First

Address _____

City _____ State _____ Zip _____

Single Married Separated Divorced Widowed

Home () _____ Cell () _____

Employed by _____ Work () _____

Email _____ Date of Birth ____/____/____

Social Security Number _____

Drivers License Number _____

Mother/Guardian's Legal Name

Name _____

Last MI First

Address _____

City _____ State _____ Zip _____

Single Married Separated Divorced Widowed

Home () _____ Cell () _____

Employed by _____ Work () _____

Email _____ Date of Birth ____/____/____

Social Security Number _____

Drivers License Number _____

Purpose of appointment _____

Who may we thank for this referral _____

Someone to notify in case of emergency not living with you:

Name _____ Phone _____

Relationship to Patient _____

Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature _____

Date _____

I give the above named office my permission to leave phone messages regarding appointments, treatment needs, monies owed, etc. on the following phone numbers:

Home _____ Work _____ Cell _____ Other _____

Signature _____

Date _____

Dental Insurance Information

Employee Name _____

Date of Birth _____

Relationship to Patient _____

Employer Name _____

Name of Insurance Co _____

Address _____

Telephone _____

Alternate ID _____ Group # _____

Social Security Number _____

Consent:

I consent to the diagnostic procedures and treatment by the dentist necessary for the proper dental care. I consent to the dentist's use and disclosure of my child's records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my child's records to the following persons who are involved in my child's care or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

Parent/Legal Guardian's Signature _____

Date _____