PARENT INFORMATION

Mother's Name:		
Phone:	Cell Phone:	
Address:		
City:	State:	Zip:
Marital Status	Birthday:	SSN:
Driver's License Number:		
Employer:		Occupation:
Business Address:		
City:	State:	Zip:
Business Phone:		E-Mail:

Father's Name:		
Phone:	Cell Phone:	
Address:		
City:	State:	Zip:
Marital Status	Birthday:	SSN:
Driver's License Number:		
Employer:		Occupation:
Business Address:		
City:	State:	Zip:
Business Phone:		E-Mail:

Guardian's Name (if applicable):			
Phone:	Cell Phone:		
Address:			
City:	State:	Zip:	
Marital Status	Birthday:	SSN:	
Driver's License Number:			
Employer:		Occupation:	
Business Address:			
City:	State:	Zip:	
Business Phone:		E-Mail:	
Do you have legal custody of this child?		Yes	No

EMERGENCY INFORMATION

Name of Relative Not Living With You:		
Phone:	Cell Phone:	
Address:		
City:	State:	Zip:

INSURANCE INFORMATION

Primary Dental Insurance Co. Name:		
Phone:	Group Number (Plan or Policy)	
Address:		
City:	State:	Zip:
Insured's Name:		SSN:

Secondary Dental Insurance Co. Name:		
Phone:	Group Number (Plan or Policy)	
Address:		
City:	State:	Zip:
Insured's Name:		SSN:

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent is covered by insurance with _____ _____(name of insurance company) and assign directly to Dr. Mayes all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Date:_____ _____

Signature of Parent, Guardian or Personal Representative

_____

Please print name of Parent, Guardian or Personal Representative

_____

Relationship to child