Family and Insurance Information

grin PEDIATRIC DENTISTRY
972.608.4746
972.608.4749 fax

Parent/Legal Guardian 1: _____ Relationship to Patient _____

Date of Birth ____/____/_____ Social Security _____-_____-_____

Cell Phone # _____ Work Phone # _____

Email _____

Address (if different from child's) _____

_____

Occupation _____ Employer _____

Parent/Legal Guardian 2: _____ Relationship to Patient _____

Date of Birth ____/____/_____ Social Security _____-_____-_____

Cell Phone # _____ Work Phone # _____

Email _____

Address (if different from child's) _____

_____

Occupation _____ Employer _____

Child's parents are ☐ Married ☐ Divorced ☐ Separated ☐ Other

DENTAL INSURANCE INFORMATION

Dental Insurance? ☐ Yes ☐ No

Policy Holder's Name _____ Date of Birth _____

Relationship to Patient _____

Employer Name _____

Dental Insurance Company Name _____

Policy Holder ID# or SS# _____ Group # _____

Insurance Phone _____

Insurance Mailing Address _____

____ (Initials) grin pediatric dentistry is an **OUT OF NETWORK** provider. This means that grin pediatric dentistry does not have any contract with any insurance companies.

____ (Initials) *Since this patient is a minor, it becomes necessary that a signed permission be obtained from the parent or legal guardian before any dental service can be performed. Authorization is hereby granted as such.*

____ (Initials) **I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform grin pediatric dentistry/ Grin Central Station LLP of any changes.**

Legal Guardian's Signature: _____Date: _____

Relationship to Patient: _____