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frontdesk@mcgrifffamilydentistry.com

Welcome

Thank you for selecting our dental healthcare team - we are pleased to welcome your child to our practice! To help us better serve the needs of your child and meet his/her dental healthcare needs, please complete the following form. If you have any questions or need assistance, please ask us - we are happy to help!

Your Child

Child's Name _____ Date _____
Wishes to be called _____ Sex F M
Birthdate _____ Age _____
Child's Home Address _____
City _____ State/Zip _____
Phone _____
Whom may we thank for referring you?

Person Responsible for Scheduling?

Name _____
Relationship to patient _____
How can we best reach you?
 Cell Email _____
 Pager Work Home
Time of Day _____

Mother

Stepmother Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. # _____
Pager _____ E-Mail _____
Employer _____ Occupation _____
SS# _____

Marital Status

Single Married Other _____

Father

Stepfather Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. # _____
Pager _____ E-Mail _____
Employer _____ Occupation _____
SS# _____

Marital Status

Single Married Other _____

Responsible Party Other Than Listed

Name _____
Relationship to patient _____
Birthdate _____ Soc. Sec. # _____
Address _____
City _____ State/Zip _____

Employer _____ Occupation _____
Work Phone _____ Ext. # _____
Home Phone _____ Cell Phone _____

Previous Dentist

Name _____
City _____

Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to Patient _____
Insured's Birthdate _____
Insurance ID. # _____
Employer _____
Occupation _____
Insurance Company _____
Group# _____
Ins. Co. Address _____
Ins. Co. Phone _____

Secondary Insurance

Name of Insured _____
Relationship to Patient _____
Insured's Birthdate _____
Insurance ID. # _____
Employer _____
Occupation _____
Insurance Company _____
Group# _____
Ins. Co. Address _____
Ins. Co. Phone _____

Authorization and Release

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of parent/guardian

Date

Thank you for filling out this form completely. The information you have provided will help us serve your child's dental healthcare needs more effectively and efficiently.