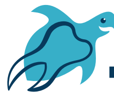

Haring PEDIATRIC DENTAL

Practice Limited to Pediatric & Adolescent Care

Child Information

Name: ____________________ Relationship: ____________________

Preferred Name: ____________________ ☐ Male ☐ Female Date of Birth: ____________

Address: ____________________ City: ____________ State: ________ Zip: ________

Referred By: ____________________

Physician's Name: ____________________ Physician's Phone: ( ) ____________

Children in Household

Name ____________ Relationship ____________ Birth Date ____________ Age ______

Name ____________ Relationship ____________ Birth Date ____________ Age ______

Name ____________ Relationship ____________ Birth Date ____________ Age ______

Name ____________ Relationship ____________ Birth Date ____________ Age ______

Name ____________ Relationship ____________ Birth Date ____________ Age ______

Responsible Party Information

Mother Name: ____________________ ☐ Single ☐ Married ☐ Divorced ☐ Other

Home #: ( ) ____________ Cell #: ( ) ____________

Address (if different): ____________ City: ____________ State: ________ Zip: ________

Social Security Number: ____________ **Date of Birth:** ____________

Employer: ____________ Work Phone: ( ) ____________

Occupation: ____________ **Email:** ____________

Father Name: ____________________ ☐ Single ☐ Married ☐ Divorced ☐ Other

Home #: ( ) ____________ Cell #: ( ) ____________

Address (if different): ____________ City: ____________ State: ________ Zip: ________

Social Security Number: ____________ **Date of Birth:** ____________

Employer: ____________ Work Phone: ( ) ____________

Occupation: ____________ **Email:** ____________

Emergency Information

Please list a local contact in an emergency (other than listed above).

Name: ____________________ Relation: ____________

Home Phone: ( ) ____________ Mobile: ( ) ____________

Responsible Party Dental Insurance Information

Primary Subscriber Name: ____________ Primary Responsible Party Employer: ____________

Dental Insurance Company Name: ____________________

Phone: ( ) ____________ Policy Number: ____________ Group Number: ____________

Secondary Subscriber Name: ____________ Secondary Responsible Party Employer: ____________

Dental Insurance Company Name: ____________________

Phone: ( ) ____________ Policy Number: ____________ Group Number: ____________

As the responsible party, I hereby agree to provide payment for all services, regardless of insurance coverage.

Signature of Responsible Party: ____________________ Date: ____________

Please Complete Other Side ▶▶▶