Great Beginnings
Pediatric Dentistry
Gentle Care for Growing Smiles

PATIENT INSURANCE

PATIENT INFORMATION

Name :: _____

Birthdate :: _____ ☐ Female ☐ Male

Child's Cell :: _____

Child's Email :: _____

Sibling we treat :: _____

_____

Home Address :: _____

_____

City State Zip

Mother's Name, Cell, and Employer :: _____

_____

_____

Father's Name and Cell and Employer:: _____

_____

_____

PRIMARY DENTAL INSURANCE

☐ Same ☐ N/A

Name of Insured :: _____

Relationship to Patient :: _____

Work Phone :: _____

Name of Employer :: _____

Insurance Comany :: _____

Member ID :: _____

Group # :: _____

SECONDARY DENTAL INSURANCE

☐ Same ☐ N/A

Name of Insured :: _____

Relationship to Patient :: _____

Work Phone :: _____

Name of Employer :: _____

Insurance Comany :: _____

Member ID :: _____

Group # :: _____

In case of emergency, please list the name, phone number, and relationship to the patient not living at home :: _____

_____

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SIGNATURE

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any/and all necessary dental services be renedered. Authorization is hereby granted for Great Beginnings Pediatric Dentistry to provide dental care for this child. Furthermore, I acknowledge receipt of the office policy as to charges and payments and agree to comply. I will be financially responsible for the charges incurred for the dental treatment of this child.

Parent/Guardian Signature_____ Relationship to Patient_____

Print Name_____ Date_____