Bitterroot Valley Dental Care

Patient Today's date_____

Name_____Nickname_____Boy____ Girl____

Birth date_____ Soc Sec #_____ School_____

Address_____ City_____State_____Zip_____

Who does child live with?_____Referred by_____

Family & Account Information

Mothers' name_____

Address_____ City_____ State_____ Zip_____

Birth date_____ Soc Sec #_____ Employer_____

Home phone_____ Cell phone_____ Work phone_____

Fathers' name_____

Address_____ City_____ State_____ Zip_____

Birth date_____ Soc Sec #_____ Employer_____

Home phone_____ Cell phone_____ Work phone_____

Name, address & phone of legal guardian (other than parent)_____

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Insurance Information

Subscribers' name_____ Relationship to child_____

Birth date_____ Soc Sec #_____ Employer_____

Insurance Co_____ Phone #_____

Subscriber ID # _____ Group #_____

Does the child have other insurance coverage? (please list)_____

I authorize my insurance company to pay directly to Bitterroot Valley Dental Care insurance benefits otherwise payable to me. I understand that I am responsible for all charges.

Signature_____ Date_____

Authorization and Release

I certify that I have, to the best of my knowledge, provided complete and correct information. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to perform treatment, payment, and healthcare operations.

Signature_____ Date_____