Farrow Pediatric Dentistry

Patient Information

Patient's Name_____ Male_____ Female_____

Address _____

Date of Birth _____ **Social Security #** _____-_____-_____ **Contact Phone#** (_____)_____

Parent/Guardian Information

Name_____**Cell #** (____)_____**Alt. Phone**(____)_____

Relationship to Patient_____Social Security# _____-_____-_____ Date of Birth_____ Marital Status_____

Employer_____ Occupation _____ # Yrs Employed _____

Name _____**Cell #** (____)_____**Alt. Phone**(____)_____

Relationship to Patient_____Social Security # _____-_____-_____Date of Birth_____Marital Status_____

Employer _____ Occupation _____# Yrs Employed_____

Email Address _____**Do you use Text Messaging?** Y _____ N _____

Who may we thank for referring you to Farrow Pediatric Dentistry? _____

Dental Insurance Information

Policy Holder _____**Date of Birth**_____**Social Security #**_____-_____-_____

Policy Holder's Employer_____ **Dental Ins Co.**_____

Group/Plan/Account/Policy #_____ Member/Subscriber ID #_____ Ins Co. Phone # (_____)_____

Ins Co. Address _____

The above information is true and correct to the best of my knowledge.

I hereby authorize **Dr. Brad Farrow**, assisted by dental auxiliaries on staff, to perform upon my child (or legal ward) dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, nitrous oxide, radiographs (x-rays) and diagnostic aids. – I have reviewed and understand this office's **Notice of Privacy Practices**. – I have reviewed and understand the **Office Policy**. -- I agree to assume full financial responsibility of payment for this account regardless of insurance coverage. I understand that any insurance estimate given to me by this office is **NOT** a guarantee of actual insurance payment or coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time. I understand that, where appropriate, credit bureau reports may be obtained. I understand that though good results are expected, the possibility and nature of complications cannot be accurately anticipated, therefore, no guarantee as to the result of treatment can be made.

Parent/Guardian's Name (PRINT)_____**Relationship to Patient**_____

Signature of Parent/Guardian_____**Date**_____