primary teeth
pediatric dentistry

Jake Fried DDS

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Parent/Legal Guardian Information

First Name:_____Last Name:_____Middle Initial____

Cell Phone: ( ) _____ - _____ HomePhone: ( ) _____ - _____

Email:_____

Address: _____

City: _____ State _____ Zip: _____

SSN: _____ - _____ - _____ Date of Birth: _____/_____/_____ Age: _____ Sex: ▫ M ▫ F

Relationship to Patient: _____

Address (if different): _____Phone:( ) _____ - _____

Child/Dependant(s) and Date of Birth

_____ _____

_____ _____

_____ _____

Dental Insurance Information

Subscriber Name: _____ Date of Birth: _____/_____/_____

Relationship to patient: _____ Employer: _____Occupation: _____

SSN: _____ - _____ - _____ Name of Dental Insurance: _____

Policy ID #: _____ Group #: _____

Assignment and Release

I, the undersigned, have insurance with _____ and assign directly to Primary Teeth Pediatric Dentistry PLLC all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Financial Agreement

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents/legal guardians are responsible for all fees and services rendered for treatment of a child/dependent. I accept full financial responsibilities for all charges, even if covered by insurance.

Name: _____ Signature:_____ Date: _____/_____/_____