Child's name	
Child's Date of Birth	
Child's Social Security Number	

In order for us to bill dental insurance directly, please complete all of the following information	
Father/Step Father/Guardian name	***Mother/Step Mother/Guardian name***
Soc. Sec. No.	Soc. Sec. No.
Date of Birth	Date of Birth
Phone	Phone
Address City/State/Zip	Address City/State/Zip
Employer Name	Employer Name
Dental Insurance Carrier Contract/Group Number	***Dental Insurance Carrier*** Contract/Group Number
Is child covered under Medicaid or Healthy Kids? ___Yes ___ No ***ID #***	

By signing below, I authorize the dental staff to perform, with my informed consent, any necessary dental services needed during diagnosis and treatment. I also authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. ***I understand that my dental insurance may pay less than the actual bill for services, and that I agree to be responsible for the payment of any unpaid balance. I further understand that I am responsible for additional fees, if any, including collection agency fees, court costs and attorney fees.***

I have been informed and understand that under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

a) Provide & coordinate my child's treatment among all healthcare providers and relevant agencies who may be involved in the treatment directly & indirectly.

b) Obtain payment from third-party payers.

c) Conduct normal healthcare operations such as quality assessments, improvement activities and physicians certification.

I acknowledge that I have been offered your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my child's health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*. I further understand that I may request in writing that you restrict how my child's protected health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature	***Date***
Name (printed)	

For future appointment scheduling would you prefer we contact you by:

___ E-mail to:

___ Postcard to father's address as shown above

___ Postcard to mother's address as shown above

Please complete other side ⇒