Patient Check In & Treatment Authorization

Patient Name	**Patient's Date of Birth**

Please complete all of the following information

Father's Name (or legal guardian)	**Mother's Name (or legal guardian)**
Social Security Number	**Social Security Number**
Date of Birth	**Date of Birth**
Phone	**Phone**
Address	**Address**
City, State ZIP	**City, State ZIP**
Employer's Name	**Employer's Name**
Dental Insurance Carrier	**Dental Insurance Carrier**

Note: Private insurance carriers must be billed prior to billing Medicaid or Healthy Kids. By not supplying us with your private insurance company information you acknowledge that you will be responsible for payment should Medicaid or Healthy Kids decline payment.

Is child covered under a Medicaid or Michigan Healthy Kids Program? _____ Yes _____ No

ID #

_____

By signing below, I 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.

Complete only if you want to authorize someone other than a parent or legal guardian to schedule or authorize treatment

I certify that I am a parent or legal guardian and have authorization to make health care decisions for this child. By signing below, I give permission for the person listed here to schedule and authorize appointment(s) and treatment(s), without my informed consent, for any dental services. I understand that I am responsible for any charges that may occur from such treatment. I understand this authorization will expire one year after signing or sooner if noted below. I further understand I can withdraw this consent at any time and all withdrawals must be submitted in writing.

Person I give permission to schedule or seek treatment(s) for my child is	**This authorization is to expire on**

Parent or Legal Guardian Sign & Date

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 certify that I am this child's parent or legal guardian with authorization to make health care decisions.

Signature	**Date**

Name (printed)