

PATIENT INFORMATION-MINOR

NAME: _____
Last First M.I. Preferred

ADDRESS: _____
Street City State Zip

DATE OF BIRTH _____ SEX M F HOME PHONE: _____

HOW SHOULD WE CONTACT YOU TO CONFIRM APPOINTMENTS? CIRCLE ONE: CELL PHONE, HOME PHONE, EMAIL OR TEXT
ACCOUNT INFORMATION

FATHER'S NAME _____ MOTHER'S NAME _____

SS# _____ DATE OF BIRTH _____ SS# _____ DATE OF BIRTH _____

ADDRESS IF DIFFERENT _____ ADDRESS IF DIFFERENT _____

PHONE _____ PHONE _____

EMPLOYER _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ EMPLOYER'S ADDRESS _____

WORK PHONE # _____ WORK PHONE # _____

DENTAL INS. WITH THIS EMPLOYER ___ Y ___ N DENTAL INS. WITH THIS EMPLOYER ___ Y ___ N

COVERAGE IS ___ PRIMARY ___ SECONDARY COVERAGE IS ___ PRIMARY ___ SECONDARY

INSURANCE CO _____ INSURANCE CO _____

GROUP# _____ GROUP# _____

ADDRESS _____ ADDRESS _____

AUTHORIZATION AND RELEASE:

I certify that the above information and the information contained on the attached dental and medical history forms are complete and accurate

I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care activities including the administration of claims for insurance benefits.

I authorize the dentist to perform diagnostic procedures and treatments on my child as may be necessary for proper dental care. I understand that it is my responsibility to follow through on proper dental care for my child, both before and after treatments, as advised by my Dentist.

I authorize release of my child's protected health care information, advice and treatment to other health care providers. I hereby authorize payment of insurance benefits directly to Hart & Olson Family Dentistry, SC, otherwise payable to me.

I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual fee for services.

I understand that I am financially responsible for payment in full on my account. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or part by my dental care payer.

I acknowledge receipt of the office Financial Policy. I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information as described above. I also understand I can revoke this consent at any time with written notice to this office.

PARENT/GUARDIAN SIGNATURE _____ DATE _____