**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 _____

SS# _____DATE OF BIRTH_____

ADDRESS IF DIFFERENT_____

_____PHONE_____

EMPLOYER_____

EMPLOYER'S ADDRESS_____

_____

WORK PHONE # _____

DENTAL INS. WITH THIS EMPLOYER ____ Y ___N

COVERAGE IS ____PRIMARY___SECONDARY

INSURANCE CO_____

GROUP# _____

ADDRESS_____

MOTHER'S NAME _____

SS# _____DATE OF BIRTH_____

ADDRESS IF DIFFERENT_____

_____PHONE_____

EMPLOYER_____

EMPLOYER'S ADDRESS_____

_____

WORK PHONE # _____

DENTAL INS. WITH THIS EMPLOYER ___Y ___N

COVERAGE IS ____PRIMARY___SECONDARY

INSURANCE CO_____

GROUP# _____

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 _____