Port Pediatric Dentistry, PC

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Patient Information and Health History Form

Child's Name: _____Nickname: _____ Date of Birth__/__/___
Street Address: _____ City: _____ State: ___Zip: _____
Home Phone: _____SSN: _____-____-_____ Age: _____ Gender: F M

PARENT INFORMATION

Parent/Legal Guardian 1: _____Relationship to patient: _____
Street Address: _____City: _____State: ____ Zip: _____
Home Phone: _____SSN _____-_____-_____Date of Birth: ____ /_____/_____
Cell Phone: _____Business Phone: _____
Email Address: _____
Dental Insurance: _____Employer _____Group #_____

Parent/Legal Guardian 2: _____Relationship to patient: _____
Street Address: _____City: _____State: ____ Zip: _____
Home Phone: _____SSN _____-_____-_____Date of Birth: ____ /_____/_____
Cell Phone: _____Business Phone: _____
Email Address: _____
Dental Insurance: _____Employer _____Group #_____

WHOM MAY WE THANK FOR REFERRING YOU?

Name: _____

portpediatric.com Phonebook Dental Office Pediatrician Other

EMERGENCY CONTACT

Name: _____Relationship:_____
Home Phone: _____Business phone: _____Cell phone: _____

HEALTH CARE PROVIDER

Child's Physician/Pediatrician: _____ Office phone: _____
Mailing Address: _____ City: _____State _____Zip:_____

AUTHORIZATION

I certify the truth of all the information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Port, otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual amount billed for services and may not cover all the services provided.** I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

_____ _____
Signature of Parent/Guardian Date