



New Patient Information
Pediatric

Patient's Name _____ Date of Birth _____ Child's Soc. Sec. # _____

Nickname _____

Parent/Guardian _____ Date of Birth _____ Address _____

Home Phone _____

Cell Phone _____ Work Phone _____ (City/ST) _____

Parent/Guardian _____ Date of Birth _____ Address _____

Home Phone _____

Cell Phone _____ Work Phone _____ (City/ST) _____ ZIP _____

Parent/Guardian e-mail address _____

Person financially responsible for the account? _____ Soc. Sec. # _____

Date of Birth: _____

I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to Timberlane Dental Group. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize Timberlane Dental Group to release all information necessary to secure payment. It is my responsibility to pay any deductibles, co-payments and any other fees not paid by insurance. I understand payment is expected at the time of service.

Patient's Signature _____ Date _____

(If patient is a minor, a parent or guardian must sign.)

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Name of Dental Insurance _____ Address _____

Please check which is applicable: Group Insurance [] Medicaid []

Name of Policy Holder _____ Group # _____ Member ID # _____

Date of Birth (Policy Holder) _____ Soc. Security # (Policy Holder) _____

Employer Name _____ Employer Phone # _____ Ins. Company Phone # _____

Secondary Dental Insurance

Name of Dental Insurance _____ Address _____

Please check which is applicable: Group Insurance [] Medicaid []

Name of Policy Holder _____ Group # _____ Member ID # _____

Date of Birth (Policy Holder) _____ Soc. Security # (Policy Holder) _____

Employer Name _____ Employer Phone # _____ Ins. Company Phone # _____

Medical Insurance (required for treatment of dental injuries sustained in an accident)

Name of Medical Insurance _____ Address _____

Please check which is applicable: Group Insurance [] Medicaid []

Name of Policy Holder _____ Group # _____ Member ID # _____

Date of Birth (Policy Holder) _____ Soc. Security # (Policy Holder) _____

Employer Name _____ Employer Phone # _____