General Information

Please fill out one form that includes all children. However, if the information is different for each child, please contact us so we can send you additional forms. (435-673-7776) All information will be kept confidential. Thank you)

Children's Information

Child's Name: _____ Birthdate:_____ Gender: _____
Child's Name: _____ Birthdate:_____ Gender: _____
Child's Name: _____ Birthdate:_____ Gender: _____
Child's Name: _____ Birthdate:_____ Gender: _____

Father/Male Legal Patient Representative

Name: _____ Relation: [ ] Father [ ] Step Father [ ] Guardian
Street Address: _____City:_____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Marital: [ ] Married [ ] Single [ ] Widow [ ] Divorced
Social Security Number: _____ Birthday: _____
Driver's License Number: _____
Occupation: _____
Employer: _____
Employment Address: _____City:_____ State: _____ Zip: _____
Work Phone: _____
Length of Employment: _____

Mother/Female Legal Patient Representative

Name: _____ Relation: [ ] Mother [ ] Step Mother [ ] Guardian
Street Address: _____City:_____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Marital: [ ] Married [ ] Single [ ] Widow [ ] Divorced
Social Security Number: _____ Birthday: _____
Driver's License Number: _____
Occupation: _____
Employer: _____
Employment Address: _____City:_____ State: _____ Zip: _____
Work Phone: _____
Length of Employment: _____

Misc. Information

With whom does the patient live? _____
Whom should we contact to confirm appointments? _____Phone:_____
Nearest Relative (not living with you) Name:_____Relation: _____
Home Phone: _____Cell Phone: _____
Name of Person Responsible for the payment of services? _____
Relation of Person Responsible for Services: _____

Who is Accompanying the Child to the Appointment?

(Please keep in mind that whomever is accompanying the child will be responsible for making all payments for services rendered the day of the visit.)

Name: _____ Relation: _____
Do you have legal custody of this child? [ ] Yes [ ] No
Is the child adopted? [ ] Yes [ ] No
Is the child in a foster home? [ ] Yes [ ] No
How did you hear about us? _____
Who may we thank for referring you? _____

Primary Dental Insurance

Do You Have Dental Insurance? [ ] Yes [ ] No
Name of Policy Holder: _____
Relationship to Patient:_____
Policy Holder's Birthdate: _____ Social Security #:_____
Employer:_____
Employer's Address: _____City:_____ State: _____ Zip: _____
Insurance Company Name: _____
Insurance Company Phone:_____
Insurance Company Address: _____City:_____ State: _____ Zip: _____
Group Number: _____
Identification Number: _____

Additional Insurance

Do You Have Additional Dental Insurance? [ ] Yes [ ] No (*If yes, please complete the following)*
Name of Policy Holder: _____
Relationship to Patient:_____
Policy Holder's Birthdate: _____ Social Security #:_____
Employer:_____
Employer's Address: _____City:_____ State: _____ Zip: _____
Insurance Company Name: _____
Insurance Company Phone:_____
Insurance Company Address: _____City:_____ State: _____ Zip: _____
Group Number: _____
Identification Number: _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer.
[ ] Cash [ ] Personal Check *(All returned checks are subject to a $35 fee, and we will not be able to take checks from you in the future.)*
[ ] VISA [ ] MC [ ] Discover [ ] AMX [ ] Care Credit

Authorization and Release

I authorize Children's Dental of Southern Utah to release any information including the diagnosis and the records of any treatment or examination rendered to my child/children during the periods of such dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I authorize and request Children's Dental of Southern Utah to use "SIGNATURE ON FILE" for my signature on all dental insurance forms to expedite computer processing of my claims.

My signature confirms that I have informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA)

I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on mine or my dependents behalf.

Signature of Parent or Guardian:_____ Date: _____
Signature of Staff Member:_____ Date: _____