

Date _____



Marysville Children's Dentistry

Your Child:

Name of Child _____ Nickname _____

Gender (circle): male female Birthdate _____

Address _____
Street Apt. # City State Zip

Home Phone (____) _____

Who may we thank for referring you to our office? _____

Emergency Contact:

Name _____ Relationship _____ Phone (____) _____

Family Information:

Please check one: Mr. Mrs. Ms. Miss Dr.

Parent 1 _____
 Parent Step-Parent Legal Guardian

Birthdate _____
Address (if different from child's) _____

E-Mail Address _____

Home Phone (____) _____

Cell Phone (____) _____

Work Phone (____) _____

Employer _____

Occupation _____

Group or Local #: _____

Subscriber of child's dental insurance? yes no
 Primary Secondary

Dental Insurance Company _____

Ins. Co. Address _____

Ins Co. Phone(____) _____

MEMBER ID or SOCIAL SEC.# _____

****ID or SS# REQUIRED IN ORDER TO BILL INSURANCE****

Please check one: Mr. Mrs. Ms. Miss Dr.

Parent 2 _____
 Parent Step-Parent Legal Guardian

Birthdate _____
Address (if different from child's) _____

E-Mail Address _____

Home Phone (____) _____

Cell Phone (____) _____

Work Phone (____) _____

Employer _____

Occupation _____

Group or Local #: _____

Subscriber of child's dental insurance? yes no
 Primary Secondary

Dental Insurance Company _____

Ins. Co. Address _____

Ins Co. Phone(____) _____

MEMBER ID or SOCIAL SEC.# _____

****ID or SS# REQUIRED IN ORDER TO BILL INSURANCE****

I am legally authorized to obtain medical/dental services for this patient. To the best of my knowledge, the questions on this form have been accurately answered. I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the release of information including the diagnosis and records of treatment/examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services.

I understand that I am financially responsible for payment of all services rendered on my or my dependents' behalf.

Signature of Parent or Legal Guardian

Print Name

Date

Christopher G. Lugo, DMD ♦ 919 State Ave. #104, Marysville, WA 98270 ♦ Phone: (360) 659-8100



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