

GENERAL INFORMATION

Guardian #1 information: Relationship to patient _____

Full Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone # (____) _____ - _____ Work Phone/Pager # (____) _____ - _____
Cell Phone # (____) _____ - _____ E-mail address _____
Date of Birth _____
Social Security # _____ - _____ - _____
Place of Employment _____
Employment Address _____
Dental Insurance Carrier _____ Group # _____
Insurance Mailing Address _____
Insurance Co. Telephone # (____) _____ - _____ Policyholder name _____

Guardian #2 information: Relationship to patient _____

Full Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone # (____) _____ - _____ Work Phone/Pager # (____) _____ - _____
Cell Phone # (____) _____ - _____ E-mail address _____
Date of Birth _____
Social Security # _____ - _____ - _____
Place of Employment _____
Employment Address _____
Dental Insurance Carrier _____ Group # _____
Insurance Mailing Address _____
Insurance Co. Telephone # (____) _____ - _____ Policyholder name _____

Person Financially Responsible _____

Relationship to Child _____
Address _____
City _____ State _____ Zip Code _____
Home # (____) _____ - _____ Work # (____) _____ - _____

Person to contact in case of emergency if you cannot be reached:

Name _____ Home # (____) _____ - _____ Work # (____) _____ - _____
Name _____ Home # (____) _____ - _____ Work # (____) _____ - _____

Whom may we thank for referring you to our office: _____

CONSENT:

Your child is a minor; therefore, it is necessary that a signed permission be obtained from a parent or guardian before any dental services can be started. I grant Indianapolis Pediatric Dentistry permission to provide my child with dental care and I will be responsible for the total cost of the dental care.

Signature _____ Date _____

FINANCIAL POLICIES

Please read the following carefully before signing.

1. Payment is due in full at the time services are rendered. As a courtesy, we will gladly file your insurance for you.
2. We accept Personal Checks, MasterCard, Visa, and Cash. A \$30.00 fee will be charged to your account for any check returned for non-sufficient funds.
3. A monthly service fee plus interest will be charged on all accounts with an outstanding balance after 30 days.
4. Cancellation policy: Our office requires 48 hours notice of cancellation. For any appointment that is not cancelled 48 hours in advance, a fee of \$50.00 per 30 minutes scheduled can be charged to your account. As we usually have patients on a waiting list, we appreciate your call if you will need to reschedule your appointment.
5. The responsible party is the parent that brings the child in for the dental visit, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

The undersigned agrees to be financially responsible for any dental charges incurred, which may include interest fees, the cost of collection agencies, court cost and any attorney fees for accounts that are not paid when due for _____.

_____ Child's Name

Signed _____ Date _____
(Parent or Guardian)