Today's Date___________________________________

Patient's Name____________________________**Male / Female** **Date of Birth**______________________

Patient's Street Address____

City, State & Zip Code____

Email Address for Appt. Confirmation:______________________________________

Cell Phone for Text Reminders:______________________________

Father's Name____ Birthdate_____________________

Employer____ Social Security #____________________

Home Phone________________________Work__________________Cell _________________________

Father's Address if Different than Child's____

Name of Dental Insurance Company____

Group or Policy #______________________________________ Insurance Phone_____________________

Insurance Co. Address____

Mother's Name_______________________________________ Birthdate__________________________

Employer____ Social Security #____________________

Home Phone________________________Work__________________Cell _________________________

Mother's Address if Different than Child's____

Name of Dental Insurance Co.____

Group or Policy #______________________________________ Insurance Phone_____________________

Insurance Co. Address____

Name of Person to Contact in Case of Emergency____

Emergency Phone________________________________ Relationship_____________________________

How Did You Hear About Us? Drive By___ Internet___ Insurance Co___ Dr./Friend________________

Our office is happy to assist patient's families who are covered by dental insurance. As a courtesy to you we will submit claims to your primary carrier and accept assignment of benefits. Our office requires that you pay your estimated portion of your bill at the time of service. Total payment of your child's charges is your responsibility, regardless of what insurance pays. Your insurance policy is a contract between your employer, you, and the insurance company. Any remaining balance not paid by insurance will be billed to you**. Please be aware, our office will not submit statements for billing to any one other than the person responsible for filling out each child's medical/dental history and other questionnaires.**

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND GIVE MY CONSENT FOR MY CHILD, ________________________, TO HAVE DENTAL PROCEDURES PERFORMED BY DR. WITTE AND HIS STAFF. I AUTHORIZE DENTAL INSURANCE BENEFITS TO BE PAID TO DR. WITTE:

Signature____Relationship to Patient________________________

Print Name____Date______________________