Patient Information

Patient's Name_____ Nickname_____
Date of Birth _____ Age_____ Sex __M __F
Home Street Address_____
City, State, Zip_____
Home Telephone_____
School/Grade_____ Email address_____
Interests and Hobbies_____
Names and ages of other children in the family_____

Parent Information

Father's Name_____ Mother's Name _____
Father's address_____ Mother's Address_____
Social Security Number_____ Social Security Number_____
Employer_____ Employer_____
Occupation_____ Occupation_____
Home Phone_____ Home Phone_____
Work Phone_____ Work Phone_____
Cell Phone_____ Cell Phone_____
Father's Date of Birth _____ Mother's Date of Birth _____

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

Method of Payment

Fees incurred are due in full when services are rendered. They are entirely the patient/guarantor's responsibility. Payments can be made by the following options:

1. We accept cash, check, Mastercard, Visa, or Discover at the time of service.
2. You are responsible for the balance of all treatment. We will file your insurance for you as a courtesy. Please understand that we are not a part of any insurance networks, and that the insurance policy is a contract between you and the insurance company. We recommend treatment based on necessity and not what your policy covers. It is your responsibility to contact the insurance to find out your coverage for treatment we have recommended. You are responsible for any portion that the insurance does not cover. All Delta Dental and Federal Blue Cross Blue Shield policy holders will be required to pay in full at the time of service, with you being reimbursed directly from that insurance company. If your child/children requires dental treatment beyond the standard cleaning and exam, payment of 30% of that days total is due at time of visit. If, for any reason, the insurance does not pay within forty-five (45) days, the balance is then due and payable in full by the parent/guarantor.
3. The parent or guardian who brings the child to the office is responsible for payment in full. All statements will be sent to this individual. We will not bill a third party.
4. In the unfortunate event we have to seek an outside collection agency for unpaid balances, the parent/guardian will be responsible for any collection and/or attorney fees.

Do you have dental insurance? Yes No Policy holder's name: _____
Claims address: _____ Insurance Name_____
_____ Plan Phone#_____
Member ID # _____ Group# _____

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with insurance company _____ and assign directly to Dr. Scott all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Dr. Scott may use and disclose my child's health care information to the above named insurance company and their agents for the purpose of obtaining payment of services and determining benefits or the benefits payable for related services

Parent Signature_____ Today's Date_____