ANCHORAGE PEDIATRIC DENTISTRY

INSURANCE INFORMATION

Child's Name:_____

RESPONSIBLE PARTY

_____
Father or Guardian's Name

_____
Address

_____
City State Zip

_____
SS# Birth Date

_____
Home phone Work phone

_____
Employer Occupation

_____
Email address Cell phone

_____
Mother or Guardian's Name

_____
Address

_____
City State Zip

_____
SS# Birth Date

_____
Home phone Work phone

_____
Employer Occupation

_____
Email address Cell phone

NEAREST RELATIVE/FRIEND

_____
Name

_____
Address

_____
Phone # Relationship

DENTAL INSURANCE

_____
Primary Insurance

_____
Policy Holder Name DOB

_____
Group #

_____
ID#

_____
Secondary Insurance

_____
Policy Holder Name DOB

_____
Group #

_____
ID#

AUTHORIZATION

I understand that I am responsible for all charges incurred by myself or my family regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If my account goes 60 days past due my balance will accrue finance charges at 19% APR or a minimum charge of $5.00, whichever is greater, which I will be held responsible. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request payment under my dental insurance program be made directly to Dr. J. Brant Darby, DDS on any unpaid bills for services furnished to my family or me. I authorize the release of any dental information necessary to process this claim and all future claims.

_____
Signature Date

The permission of parent or guardian is necessary for dental treatment of a minor:
I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen, dust, or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions, that my child's medical doctor has advised me should be reported to a dentist.

_____
Signature Relationship to Child Date