Smiles 4 Kids
Children's General Dentistry

(*Please fill in ALL of the required fields*)

*MOTHER/GUARDIAN: _____

*Address: _____

City: _____ State: _____ Zip: _____

*Email: _____

*Home Phone: _____ Cell: _____ Work: _____

*Date of Birth: _____ *Social Security #: _____

◯ Married ◯ Divorced ◯ Single ◯ Other: _____

*FATHER/GUARDIAN: _____

*Address: _____

City: _____ State: _____ Zip: _____

*Email: _____

*Home Phone: _____ Cell: _____ Work: _____

*Date of Birth: _____ *Social Security #: _____

◯ Married ◯ Divorced ◯ Single ◯ Other: _____

****Has your child had an appointment with any other Dental office since the last time they were seen here? ** YES _____ **NO _____**

**** If the procedure isn't covered by your insurance due to previous appointment elsewhere you will be responsible for the balance on your account.**

*****Insurance is a contract between you and your insurance provider. We will bill your insurance company as a courtesy to you. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits. You agree to pay any portion of the charges not covered by insurance. I hereby authorize payment by my dental insurance company be directly made to Smiles 4 Kids, LLC. I also authorize the release of any dental information necessary to process all dental claims. I understand that I am ultimately responsible for all costs of dental treatment provided for me or my family regardless of insurance coverage.**

*****Legal Guardian Signature:** _____ **Date** _____