

Patient Information Form
Anne R. Lee, DDS Pediatric Dentistry

Patient's Last name _____ **First name** _____
Nickname _____ Birthdate _____ Sex: M F
Address _____ School _____
_____ Grade _____

Responsible Party

With whom does patient live? _____ Person responsible for account _____
Who brought patient today? _____ Does patient have dental insurance? _____

Parent or Guardian Information

___ Mother ___ Stepmother ___ Guardian

Name _____ SSN _____ Birthdate _____
Address _____ Driver's license no. _____
_____ Employer _____
Phone: Mobile _____ Title _____
Home _____ Work phone _____

___ Father ___ Stepfather ___ Guardian

Name _____ SSN _____ Birthdate _____
Address _____ Driver's license no. _____
_____ Employer _____
Phone: Mobile _____ Title _____
Home _____ Work phone _____

Primary Insurance Carrier _____ Name of insured _____
Contract no. _____ Group no. _____

Secondary Insurance Carrier _____ Name of insured _____
Contract no. _____ Group no. _____

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

I have reviewed the information on this form and it is accurate to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist insurance benefits. Furthermore, I understand that, even though I may have dental insurance, I am responsible for all financial obligations that may arise as a result of any dental treatment provided for my child.

Signature of Parent/Guardian

X _____
Date _____