

PREVENTATIVE DENTAL CARE

How often does your child brush? _____
Is tooth brushing supervised? Yes No
By whom? _____
Do you help your child brush? Yes No
Is dental floss used? Yes No
Does your child receive?
Fluoride in vitamins Bottled water
Fluoride tablets/drops Well water
Fluoridated water

DENTAL INSURANCE

Primary Insurance _____ Group# _____
Policy Holder Name _____ ID# _____
Secondary Insurance _____ Group# _____
Policy Holder Name _____ ID# _____

NEAREST RELATIVE/FRIEND

Name _____
Address _____
Phone # _____ Relationship _____

RESPONSIBILITY

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

AUTHORIZATION

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If my account goes 90 days past due my balance will accrue finance charges at 19% APR or a minimum charge of \$2.50, 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 me or my family. 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

Reviewed By