Fox Kids
DENTISTRY & ORTHODONTICS

General Information

Patient Name: _____ Nickname (if any): _____

Date of Birth: _____ Sex: M F

Home Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Alternate Phone: _____

Preferred Email: _____ Alternate Email: _____

Parent #1: _____ Date of Birth: _____

Employer: _____ Work Phone: _____

Parent #2: _____ Date of Birth: _____

Employer: _____ Work Phone: _____

Parents' Marital Status: Single Married Divorced Separated Widow(er)

How did you hear about our office? (New patients only): _____

Insurance Information

Primary Insurance Company: _____ Policy #:_____

Name of Subscriber: _____ Group #: _____

Secondary Insurance Company: _____ Policy #:_____

Name of Subscriber: _____ Group #: _____

Name of person/parent responsible for patient account: _____

Billing Address (if different than home): _____

City: _____ State: _____ Zip: _____

Please sign below authorizing Fox Kids Dentistry & Orthodontics, LLC to submit any insurance claims as well as to provide each respective insurance company, claim administrator and consulting health care professional information concerning health care, advice, treatment, or supplies provided. This form also authorizes release of any information relating to a claim submitted on your behalf. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

Parent/Guardian Signature: _____

Print name: _____

Relation to patient: _____ Date: _____

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