Fox Kids
DENTISTRY & ORTHODONTICS

General Information

Patient First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Preferred name: _____ Date of Birth: _____ Sex: M F

Parent #1: _____ Date of Birth: _____

Preferred Phone: _____ Cell Home Work Alternate Phone: _____

Employer: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Parent #2: _____ Date of Birth: _____

Preferred Phone: _____ Cell Home Work Alternate Phone: _____

Employer: _____ Email: _____

Home Address: □ Same as above □ Other: _____

City: _____ State: _____ Zip: _____

Child lives with: Both parents Parent 1 Parent 2 Other: _____

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

Insurance Information

Name of person/parent responsible for patient account: _____

Primary Insurance Company: _____ Policy #:_____

Name of Subscriber: _____ DOB: _____ Group #: _____

Secondary Insurance Company: _____ Policy #:_____

Name of Subscriber: _____ DOB: _____ Group #: _____

I authorize Fox Kids Dentistry & Orthodontics to submit any insurance claims, as well provide each respective insurance company, and claim administrator. 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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