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 Email: _________________________________

Home Address: ____

City: ____ State: ___________ Zip: ________________

Parent #2: ____ Date of Birth: ____________________________

Preferred Phone: _________________________ Cell Home Work 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

◻ Cash Pay ◻ Oregon Health Plan (Medicaid) ◻ Private Insurance

Primary Insurance Company: ___________________________________ Policy #:__________________________

Name of Subscriber: __________________________________ DOB: ________ Group #: _________________________

Insurance through: ◻ Self ◻ Employer: ____

Secondary Insurance Company: _________________________________ Policy #:__________________________

Name of Subscriber: __________________________________ DOB: ________ Group #: _________________________

Insurance through: ◻ Self ◻ Employer: ____

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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