Treasured Smiles
PEDIATRIC DENTISTRY, LTD

Specializing in Dentistry for Children and Adolescents

Welcome!

Tell us about your child or children

Name:_____ male/female Birth date:____/____/____

Name:_____ male/female Birth date:____/____/____

Name:_____ male/female Birth date:____/____/____

Name:_____ male/female Birth date:____/____/____

Responsible Party Information

Name of Father/Guardian: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

Date of Birth: _____-_____-_____ SSN: _____-_____-_____ Drivers License #: _____

E-mail Address: _____

Employer: _____ Occupation: _____

Employer Address: _____

Name of Mother/Guardian: _____

Address:□same_____ City: _____State: _____ Zip: _____

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

Date of Birth: _____-_____-_____ SSN: _____-_____-_____ Drivers License #: _____

E-mail Address: _____

Employer: _____ Occupation: _____

Employer Address: _____

Parent that Child Resides With: _____

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

We are excited to know if you were referred to us by any of our other sources:

□ Family Time Magazine
□ Frankfort HomePages
□ Frankfort Station
□ Frankfort/Tinley Yellow Pages
□ Google
□ Greater Will County Yellow Pages
□ Internet / Website
□ Internet Yellow Pages
□ Mokena HomePages
□ Mokena Messenger
□ New Lenox HomePages
□ New Lenox Patriot
□ Orland Park Yellow Pages
□ Parent Magazine
□ Sun Newspaper
□ Other_____

****Please Complete the Reverse Side of This Form****

Insurance Information

As a courtesy, our office can file insurance claims on your child's behalf.

□ We **DO NOT** have dental insurance. I will be paying by the following methods at the time of service…

□Cash □Personal Check □Credit Card
□CareCredit (payment plan option)

□We **HAVE** Dental Insurance. I will be paying for my portion of services rendered with the above method at the time of treatment, and my insurance company will be billed for their portion by Treasured Smiles Pediatric Dentistry, Ltd. My insurance information is provided below.

The person with the earliest birth date in the calendar year is the primary insured

Primary Insured's Name: _____ Date of Birth: ____/____/_____

Social Security Number: _____-_____-_____

Employers Name: _____ Work Phone: (_____) _____

Work Address:_____ City: _____ State: ___ Zip: _____

Insurance Company: _____ Insurance Co. Phone: (_____) _____

Insurance Co. Address: _____ City: _____ State: ____ Zip: _____

Group or Plan Number: _____ Policy Number: _____

Union Name: _____ Local #: _____

□We have Secondary Insurance as well…

Secondary Insured's Name: _____ Date of Birth: ____/____/_____

Social Security Number: _____-____-_____

Employers Name: _____ Work Phone: (_____) _____

Work Address:_____ City: _____ State: ___ Zip: _____

Insurance Company: _____ Insurance Co. Phone: (_____) _____

Insurance Co. Address: _____ City: _____ State: ___ Zip: _____

Group or Plan Number: _____ Policy Number: _____

Union Name: _____ Local #: _____

Authorization and Release

I, the undersigned (parent or legally responsible party), authorize all dental treatment to be rendered by the dentist and staff of Treasured Smiles Pediatric Dentistry, Ltd. I will keep the office informed of changes in my child's health, address or financial information. I authorize Treasured Smiles Pediatric Dentistry, Ltd. to release any information including the diagnosis and records of any treatment or examination of my child to third party payors. I authorize Treasured Smiles Pediatric Dentistry, Ltd. to submit insurance claims on my behalf, and assign directly to Treasured Smiles Pediatric Dentistry, Ltd. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of signature on all my insurance submissions, whether manual or electronic. I assume full financial responsibility for all fees of services rendered, regardless of the level of reimbursement by the insurance plan. I understand that the insurance plan is a contract between the employer of the person who is insured and the insurance company, and not a contract with the dental office. I understand that treatment plans may change during treatment, and will be informed of the changes, but am still responsible for payment. I certify that I have accurately answered all of the questions asked of me to the best of my knowledge.

x_____ _____
Signature of parent or guardian Date