

## Child Patient Information Form

<b>Child Information</b>	last name	first name	middle name	preferred name
	street address		city	state zip [ ] Male [ ] Female
	home phone	social security number	birth date (mm/dd/yyyy)	sex
	referred by		present dentist	
	emergency contact			phone
	physician			phone
	physician address		city	state zip
<b>Parent Information</b>	last name	first name	middle name	preferred name
	street address		city	state zip
	home phone	work phone	cell phone	email
<b>Primary Dental Insurance</b>	insured's name		insured's employer	
	insured's birth date	insured's social security number or identification number		relationship to patient
	insurance company		phone number	group number
	insurance company address		city	state zip
<b>Secondary Dental Insurance</b>	insured's name		insured's employer	
	insured's birth date	insured's social security number or identification number		relationship to patient
	insurance company		phone number	group number
	insurance company address		city	state zip

I authorize Dr. Lefkoff to release any information requested by any third party payer regarding charges incurred by this patient. In addition, I authorize the use of the signature on all insurance submissions.

Signature

Date