MillCreek
CHILDREN'S DENTISTRY

Date:_____

Name of Child_____Nickname_____

Gender*(circle)*: male female Birthdate_____

Address_____
Street *City* *State* *Zip*

Home Phone(_____)_____

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

Emergency Contact:

Name_____Relationship_____Phone(____)_____

Family Information:

Please check one: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr.	*Please check one*: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr.
Parent 1_____	Parent 2_____
□ Parent □ Step-Parent □ Legal Guardian	□ Parent □ Step-Parent □ Legal Guardian
Birthdate_____	Birthdate_____
Address (if different from child's)	Address (if different from child's)
_____	_____
_____	_____
Home Phone (_____)_____	Home Phone (_____)_____
Cell Phone (_____)_____	Cell Phone (_____)_____
Work Phone (_____)_____	Work Phone (_____)_____
E-mail Address _____	E-mail Address _____
Employer_____	Employer_____
Subscriber of child's dental insurance? □yes □no	Subscriber of child's dental insurance? □yes □no
□ Primary □ Secondary	□ Primary □ Secondary
Dental Insurance Company_____	Dental Insurance Company_____
Ins. Co. Address_____	Ins. Co. Address_____
_____	_____
Ins Co. Phone(_____)_____	Ins Co. Phone(_____)_____
MEMBER ID or SOCIAL SEC.#_____	**MEMBER ID or SOCIAL SEC.#**_____
****ID or SS# REQUIRED IN ORDER TO BILL INSURANCE****	****ID or SS# REQUIRED IN ORDER TO BILL INSURANCE****
Group #_____	**Group #**_____

I am legally authorized to obtain medical/dental services for this patient. To the best of my knowledge, the questions on this form have been accurately answered. I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the release of information including the diagnosis and records of treatment/examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. *There will be a $35.00 charge for all missed appointments and for all appointments cancelled without 48 hours notice.

I understand that I am financially responsible for payment of all services rendered on my or my dependents' behalf.

_____/_____ _____
Signature of Parent or Legal Guardian Print Name Date

Leland Shenfield, DDS, MSD
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