Children's Dental Care

Blake Wullbrandt, DDS

PATIENT INFORMATION

Patient's Full Name_____ Nickname_____ Age_____ Sex_____

Date of Birth_____ Interests/Hobbies_____

Mailing Address_____

City_____ State_____ Zip_____

Physician's Name_____ Phone_____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Mother's Name_____ Birth Date_____

Guardian's Name (if other than mother)_____ Relationship to Patient_____

Social Security Number_____ Occupation_____

Mailing Address_____

City_____ State_____ Zip_____

Father's Name_____ Birth Date_____

Guardian's Name (if other than father)_____ Relationship to Patient_____

Social Security Number_____ Occupation_____

Mailing Address_____

City_____ State_____ Zip_____

METHODS OF CONTACT

Responsible Party Home Phone_____

Responsible Party Cell Phone_____

Responsible Party E-mail address_____

Preferred Method of Contact for Reminder Calls **(Check One)**: _____Home _____Cell (text) _____E-mail

Emergency Contact **(other than parent)**_____ Relationship to Child_____ Phone_____

Authorization To Treat

I hereby authorize payment directly to Blake Wullbrandt, DDS of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Blake Wullbrandt, DDS to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this form is correct to the best of my knowledge. I grant the right to the dentist to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or other health professionals. In the event should your account be turned over to our collection agency for non-payment, there will be a 30% increase added to your balance to defray the costs the collection agency charges us.

Signature _____ **Relationship to Patient**_____ **Date**_____

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Insurance Information Form

All information below is required in order that we may process your insurance and charge you only co-pay. If help is needed in completing this form, contact your insurance company or human resources department. We are unable to acquire this information on your behalf.

Co-pays are due on the day of service. If you do not carry insurance or cannot provide your complete insurance information, full payment is due on the day of service. Please bring your dental card to your appointment.

STATE Medicaid (List out children's names and their Medicaid ID number)

_____

_____

_____

Private Primary Dental Insurance

Child/Children's Name/s: _____

Policy Holder's (PH) Name: _____ Relationship to patient: _____

PH Address/City/State/Zip: _____ PH Phone: _____

PH Social Security Number: _____ PH Date of Birth: _____

PH Employer: _____ Phone: _____

Address/City/State/Zip: _____

Dental Insurance Company: _____ Phone: _____

Address/City/State/Zip: _____

Insurance ID number: _____ Group Number: _____

Private Secondary Dental Insurance

(Determined by Policy Holder's month of birth)

Policy Holder's (PH) Name: _____ Relationship to patient: _____

PH Address/City/State/Zip: _____ PH Phone: _____

PH Social Security Number: _____ PH Date of Birth: _____

PH Employer: _____ Phone: _____

Address/City/State/Zip: _____

Dental Insurance Company: _____ Phone: _____

Address/City/State/Zip: _____

Insurance ID number: _____ Group Number: _____