PARENT INFORMATION

Father's Name _______________ Social Security _______________

Date of Birth _______________ Calif. Driver's Lic. # _______________

Mother's Name _______________ Social Security _______________

Date of Birth _______________ Calif. Driver's Lic. # _______________

Home Address _______________

Home Phone _______________

Secondary Address _______________

Father's Occupation _______________ Cell Phone _______________

Name of Employer _______________ Address _______________

Mother's Occupation _______________ Cell Phone _______________

Name of Employer _______________ Address _______________

Do mother, father and child live together? Yes _______ No ________

If no, please explain _______________

Emergency Contact Information

Name _______________ Phone _______________ Relationship _______________

OUR OFFICE POLICY ON FEES AND FINANCIAL ARRANGEMENTS

It is our policy to discuss our fees and financial arrangement openly and honestly with you. Regardless of whether you have dental insurance or not, you are responsible for the full financial cost of the dental treatment. We will make every effort to estimate the total cost of dental treatment prior to your treatment.

Payment is expected as dental services are performed unless financial arrangements have been previously made with our office. For your convenience, we gladly accept personal checks and most major credit cards including VISA, Mastercard, and Discover. We also offer a dental charge card, Dencharge.

Please make every effort to keep your appointments. With children in school and parents at work, everyone's time, including ours, is valuable. We make every effort to confirm your appointments. Since appointments are reserved, there may be an office charge for a failed appointment or a short notice of cancelled appointment.

The mouth, gum, and teeth are constantly changing due to the progressive nature of dental disease. The actual cost of dental treatment may differ from the estimate due to our treatment of this progressive dental disease. In the event the actual costs of dental treatment differ from the estimated costs, you will be responsible for any additional cost. Every effort will be made to notify you if this occurs.

If you have dental insurance, every effort will be made to estimate the portion of the total cost that may be covered by your dental insurance plan. If you wish, our office will process an insurance claim for payment of dental treatment payable directly to us. You will then pay only your portion as discussed on your financial arrangement plan. There will be a nominal fee, however, for insurance claim processing. If you wish to process the insurance claim for payment yourself with the payment coming directly to you, then you will be required to pay us for the entire cost of the dental treatment as discussed on your financial arrangements plan.

If we process our insurance claim, we will wait up to 60 days for payment from your insurance company. If we have not received payment, we will then bill you and have you contact your insurance company for payment of their portion to you. If we process you insurance claim and payment is denied or is less than our estimated of your coverage, you will be billed the remainder. If you receive any communication from your insurance company about fess and/or dental services performed, please contact our office immediately.

BILLING INFORMATION

Person to Bill: Father Mother Other _______________

DENTAL INSURANCE INFORMATION

Father's Insurance Company _______________ Group No. _______________

Address _______________ City _______________ State _______________ Zip _______________

Insurance Company Phone No. _______________

Mother's Insurance Company _______________ Group No. _______________

Address _______________ City _______________ State _______________ Zip _______________

Insurance Company Phone No. _______________

FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for the payment of all services and agree that I will take the responsibility for any and all costs incurred by my failure to remit for services rendered.

Close estimation

Signed (Parent/Legal Guardian) _______________ Date _______________