Confidential Patient Information

(*Please Print Legibly)*

FRANZISKA K. DUTTON, D.D.S. CHILD/MINOR

Today's date: _____

PERSONAL INFORMATION

Referred by: _____

Child/Minor Name: _____ SS #: ____-____-____

❑Parent or ❑ Guardian Name: _____ SS #: ____-____-____

Address: _____ City: _____ State:_____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

e-mail: _____ *Ck Preferred Contact No.* Home [ ] Work [ ] Cell [ ] e-mail [ ]

Birth date: _____ Sex: ❑M ❑F Marital Status: _____ Spouse: _____

Occupation: _____ Spouse Occupation: _____

Sibling's Names and Ages: _____

Reason for your Initial Visit: _____

State any "Concern" or "Fear" of Dental Treatment?_____

PERSON RESPONSIBLE FOR ACCOUNT Check if listed above [ ] and skip this box.

Name: _____ Relationship: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Home)_____ (Work) _____ (Cell) _____

DENTAL INSURANCE INFORMATION

1. **Primary Insurance Co**: _____Policy # _____

Group Plan: _____ Group Plan # _____

Insurance Co. Address: _____

Insured Person's Name: _____ Birth date: _____ SS# _____

Employer: _____

Relationship: _____ Union: _____ Union Local # _____

2. **Secondary Insurance Co**: _____ Policy # _____

Group Plan: _____ Group Plan # _____

Insurance Co. Address: _____

Insured Person's Name: _____ Birth date: _____ SS# _____

Employer: _____

Relationship: _____ Union: _____ Union Local # _____

I have read the Office Policy and understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE: _____ **DATE:** _____