Welcome

Please take a few minutes to fill out the questionnaire so we can best serve your needs.
Thank you very much for your attention.

Name _____ Nickname _____
Last First Middle Initial

Date of Birth __/__/_____ Age _____ Sex _____ Social Security Number _____

Address _____ City _____ State ____Zip _____

Parent/Legal Guardian's Name _____

☐ I am not the legal guardian, but I have permission from the legal guardian to authorize children's Happy Teeth to perform any dental care as needed.

Home Phone ( ) _____ Parent's Work Phone ( ) _____

Parent's Cell phone ( ) _____ **E-mail** _____

☐ Please mark this box if you DO NOT want to be receiving text messages through your cell phone.

Primary Insurance (Leave blank only if no dental benefits)
Subscriber _____ Relationship _____
Date of birth _____ SS Number _____
Address (if different)_____
City _____ State ____ Zip _____
Phone ( )_____ Cell Phone ( )_____
Insurance Company _____
Address _____Phone_____
City_____ State ____ Zip _____
Group# _____ Subscriber# _____

Secondary Insurance
Insurance Company _____
Subscriber _____ Relationship _____
Date of birth _____SS Number _____

Responsible Party Information
Name _____
Relationship _____
Date of birth _____
SS Number _____
Address (if different) _____
City_____ State ____ Zip _____
Phone ( ) _____
Cell Phone ( )_____
Employer _____
Work ( ) _____

In case of emergency, contact _____ Phone ( ) _____
How did you hear about our office? _____

Informed Consent

I hereby authorize the dentists and staff at **Children's Happy Teeth / Happy Braces** to perform diagnostic aids including x-rays, models and photographs as appropriate to make a thorough diagnosis of my child's dental needs.
I authorize my insurance company to pay the dentist(s) all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions. I authorize the dentist(s) to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that I will be charged 18% APR for any past due balances over 60 days.

_____ _____ _____ _____
Signature **Date** **Dentist Signature** **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved.