Pediatric Dentistry
OF PROSPECT

502.292.1160 • 12927 W. Highway 42 • Prospect, KY 40059

Date:_____

Patient:_____ Nickname:_____

Birthdate:_____ Gender: ☐ M ☐ F Home or Cell Number:_____

Home Address:_____

Street Address City State Zip Code

School:_____ Grade:_____

☐ Yes ☐ No Do we see other children in your family? Names:_____

Whom may we thank for referring you to us?_____

1. Parent / Guardian Name:_____

   SSN:_____ Date of Birth:_____ Employer:_____

   Address (if different from child):_____

   Home Phone:_____ Cell Phone:_____ Work Phone:_____

   E-mail:_____

2. Parent / Guardian Name:_____

   SSN:_____ Date of Birth:_____ Employer:_____

   Address (if different from child):_____

   Home Phone:_____ Cell Phone:_____ Work Phone:_____

   E-mail:_____

Emergency Contact (other than parent/guardian):_____

Name Relationship Phone #

Person responsible for payment on account:_____

☐ Yes ☐ No Dental Insurance? Subscriber's Name:_____

Relationship to child:_____ Date of Birth:_____

Employer:_____ Insurance Company:_____

Subscriber's SSN:_____ Policy ID:_____ Group:_____

☐ Yes ☐ No Secondary Dental Insurance? Subscriber's Name:_____

Relationship to child:_____ Date of Birth:_____

Employer:_____ Insurance Company:_____

Subscriber's SSN:_____ Policy ID:_____ Group:_____

Physician's Name:_____ Physician's Phone:_____

TREATMENT AUTHORIZATION

I hereby authorize Dr. Danielle M. Haman-Smith or the dental auxiliaries under her supervision to perform any necessary dental treatment upon my child, including but not limited to the use of local anesthetic, radiographs (x-rays) and/or Nitrous Oxide (laughing gas). I understand that no services will be performed without my knowledge.

*******Please bring this form filled out and you will sign at your visit.*******

Insurance coverage varies between insurance companies and policies. If you are unsure of your insurance coverage for fluoride, please ask a receptionist and she will be happy to give you the information. Some insurance will pay for the procedure every six months. Others only pay once per year.

Fluoride $29.00

Please initial your choice below:

_____ *I would like my child to receive fluoride treatments every 6 months. I understand if my insurance does not cover this procedure, I will be billed.

_____ *I would like my child to receive fluoride only if it is a covered benefit under my insurance policy.

Signature of Parent or Legal Guardian:_____ Date:_____

Witness:_____ Date:_____