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# Welcome

Thank you for selecting our dental healthcare team - we are pleased to welcome your child to our practice! To help us better serve the needs of your child and meet his/her dental healthcare needs, please complete the following form. If you have any questions or need assistance, please ask us - we are happy to help!

## Your Child

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
 Wishes to be called \_\_\_\_\_ Sex  F  M  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Child's Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Whom may we thank for referring you?  
 \_\_\_\_\_

## Person Responsible for Scheduling?

Name \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
**How can we best reach you?**  
 Cell  Email \_\_\_\_\_  
 Pager  Work  Home  
 Time of Day \_\_\_\_\_

## Mother

Stepmother  Guardian

Name \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Ext. # \_\_\_\_\_  
 Pager \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 SS# \_\_\_\_\_

### Marital Status

Single  Married  Other \_\_\_\_\_

## Father

Stepfather  Guardian

Name \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Ext. # \_\_\_\_\_  
 Pager \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 SS# \_\_\_\_\_

### Marital Status

Single  Married  Other \_\_\_\_\_

## Responsible Party Other Than Listed

Name \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State/Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Ext. # \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Previous Dentist

Name \_\_\_\_\_  
 City \_\_\_\_\_

## Dental Insurance Information

### Primary Insurance

Name of Insured \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insured's Birthdate \_\_\_\_\_  
Insurance ID. # \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Ins. Co. Phone \_\_\_\_\_

### Secondary Insurance

Name of Insured \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insured's Birthdate \_\_\_\_\_  
Insurance ID. # \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Ins. Co. Phone \_\_\_\_\_

## Authorization and Release

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

Thank you for filling out this form completely. The information you have provided will help us serve your child's dental healthcare needs more effectively and efficiently.