DENTAL INSURANCE INFORMATION

CHILD'S NAME ____

Primary **Insurance Co Name** _________________________ Phone Number ______________

Primary Insured ______________________________________ ID# _______________________

Date of Birth of Primary Insured ________________________ Group # ____________________

Employer of Primary Insured ____

Secondary **Insurance Co Name** _______________________ Phone Number ______________

Primary Insured ______________________________________ ID# _______________________

Date of Birth of Primary Insured _____________________________ Group #________________

Employer of Primary Insured ____

MEDICAL/DENTAL RELEASE STATEMENT:

I give my consent for the doctor of Kidz-R-Kool Pediatric Dentistry to do a complete and thorough examination on the patient named above, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Kidz-R-Kool Pediatric Dentistry of any future changes to my child's medical or dental status. As the parent or legal guardian of the patient named above, I do hereby grant the doctor of Kidz-Kool Pediatric Dentistry and staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved. ______________ (***initial***)

REQUIREMENT FOR FILING INSURANCE CLAIMS. To expedite the filing of my dental insurance claims**, I do hereby authorize the release of confidential information** to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within thirty (30) days of treatment. I hereby authorize payment of insurance benefits directly to Kidz-R-Kool Pediatric Dentistry or the dentist that performs treatment on my child. Furthermore, in the event of payment default for services preciously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount. ________________(***initial***)

Parent or Legal Guardian Signature _____________________ Date ___________________

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