



## Parent or Guardian Information

### Mother/Guardian Information:

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Best time to call: \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Father/Guardian Information:

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Best time to call: \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient's relationship to insured:  Child  Other \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Street City State Zip Code

### Secondary

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient's relationship to insured:  Child  Other \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Street City State Zip Code

### Referral Information

Whom may we thank for referring you to our practice?  Friend  Relative  Dental Office  Yellow Pages  
 Internet  School  Work  Insurance List Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

This office will help prepare the patients insurance forms, submit them to your insurance company and assist in resolving any unpaid claims. The patient is responsible for all charges if insurance does not pay. All estimates for dental work to be performed are estimates only and do not commit your insurance company to payment.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

Checks returned for insufficient funds are charged a \$20 service fee and if not resolved within 10 days will be collected at 3 times the face value of the check. Parent or guardian is responsible for all costs incurred for collecting debts including but not limited to attorney and collections agency fees.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I hereby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions and assign directly to Lucinda Ann Lewis DDS, PC all insurance benefits, if any, otherwise payable to me for services rendered.

I authorize Dr. Lewis and the dental staff to perform all the necessary dental service for my minor child.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Please provide the name and phone number of **two people not living with you** who can contact you in event of an emergency or if we are unable to reach you:

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship: \_\_\_\_\_

### Payment Options:

Cash pay patients will receive a 10% discount on all services.

Payment plans are available through [www.carecredit.com](http://www.carecredit.com)

- I wish to pay cash at the time of service.
- Please bill my insurance company and I will pay my co-payments at the time of service with cash, check or credit card.

- Please keep my credit card number on file and bill the balance to my card after my insurance pays.

Credit card # \_\_\_\_\_ Exp date \_\_\_\_\_