Annapolis Pediatric Dentistry

41 Old Solomon's Island Rd., Suite 103

Annapolis, MD 21401

Patient Information		
Patient/ Child's Full Legal Name:	Date of Birth:	Sex:
Home Address:		
Parent/ Guardian Name:	Phone Number:	
Email Address:	Preferred Language?	

Insurance Subscriber Information		
Subscriber Name:	Date of Birth:	Social Security #:
Name of Employer/Company:		

PRIMARY Insurance Information	
Insurance Company Name:	Insurance Provider Phone #:
Member/Subscriber ID#:	Group/ Plan #:
Claims Address:	

SECONDARY Insurance Information (if applicable)	
Insurance Company:	Insurance Provider Phone #:
Member/Subscriber ID#:	Group/ Plan #:
Claims Address:	

Medical History (Check ALL that apply)

__Abnormal Bleeding	__ Convulsions/Epilepsy	__Heart Defect	__ Recent Hospital Stay
__ADD/ADHD	__ Diabetes	__Handicaps/Disabilities	__ Rheumatic/Scarlet Fever
__Asthma	__ Depression	__Hearing Impairment	__Tuberculosis (TB)
__Anxiety	__Hemophilia	__Kidney/Liver Problems	**List Surgeries**: _____
__Artificial Bones/Joints/Valves	__Hepatitis	__ Lupus	
__Cancer	__HIV+ /AIDS	**Other Medical/Mental History**: _____	

List Current Medications: _____ **List ALL Allergies**: _____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the legal parent/guardian/representative of_____ and there are no court orders
Print Name of Child

Now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to preform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with_____ and assign directly to Dr. Beverly Jimenez
Name of Insurance Company(ies)

all insurance benefits, if any. Otherwise, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use or my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the payable for related services.

_____ _____ _____

Signature of Parent/Guardian/Representative | Print Name | Today's Date