Welcome to PDS:

Thank you for selecting our dental healthcare team. We strive to make each of child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's name _____

Nickname _____Sex _____

Birth date _____Age _____

School _____Grade _____

Email _____

Responsible Party

Name _____

Relationship _____

Address_____

City _____ State _____

Zip _____ Phone _____

How did you find out about our practice? _____

Who is responsible for making appointments?

Name _____ Best time to call _____

Home phone _____ Cell phone _____

Emergency Contact name/telephone(Close relative, neighbor, ect.) _____

Primary Insurance

Insured's name _____

Relationship _____

Birth date _____ SSN_____

Home phone _____ Work Phone _____

Cell phone _____ Email Address _____

Occupation _____ Employer _____

Insurance Company _____

I have or will be informed of my treatment plan and associated fees. I agree to be responsible for all charges that I consent to for dental services and materials not paid for by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted by law. I consent to Pediatric Dental Specialists of Williamsburg, Pllc's use and disclosure of my protected health information to carry out payment activities in connection with claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dental entity, Pediatric Dental Specialists of Williamsburg, Pllc.

X_____

Signature of Legal Guardian/Responsible Party Date