WELCOME TO OUR OFFICE

FRANK R HODGES DDS * RAYMOND RAMOS DDS

Patients Name_____ Date of Birth _____ Sex M F

- Is this your child's first visit to a dentist yes_____ no_____

  If no, name of previous dentist? _____ Last visit? _____

- What is your primary reason for seeking dental care? _____

Whom may we thank for referring you?_____

GENERAL INFORMATION

Name of Father (Mr Dr) _____ Marital Status : Married__Single__Divorced__Partner__

Address _____ Zip Code_____

Home Phone _____ Work Phone _____Cell Phone _____

Employer _____ Occupation_____

Address _____

Name of Mother (Ms Mrs Dr)_____ Marital Status: Married__Single__ Divorced__ Partner__

Address _____ Zip Code _____

Home Phone _____ Work Phone _____Cell Phone _____

Employer _____ Occupation _____

Address _____

Emergency Contact _____Relationship_____Phone#_____

(Excluding parents)

Authorization and Release: I authorize the dentist/dental staff to perform the necessary dental services that my child may need. I also authorize the dentist/dental staff to release any information, including diagnosis and/or x-rays rendered, to my child during the period of such care to any third party payers and/or health providers. I certify that I am financially responsible for the above named patient and any charges that may occur. I further acknowledge the receipt of the HIPPA Privacy Form.

Signature of Parent/Guardian:_____**SS #**_____**Date** _____

Please complete reverse side of this form

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INSURANCE INFORMATION

Insured person#1_____ Relation to patient _____

Social Security Number _____ Date of Birth _____ Ins. ID # _____

Employer _____Group Policy # _____ Phone#_____

Name of Insurance Co._____ Address_____

Insured person #2_____ Relation to patient _____

Social Security Number _____ Date of Birth _____ Ins. ID # _____

Employer _____ Group Policy # _____Phone #_____

Name of Insurance Co._____ _____ Address _____

Whom does the child reside with?_____

Assignment of Benefits: I hereby authorize payment directly to the above named dentist of the group dental benefits otherwise payable to me. I understand that I am financially responsible for 100% of all charges incurred regardless of any insurance benefits.

Signature: _____ **Date**_____

*** This note is to clarify the financial procedures in our office so that we can avoid any misunderstandings in our future relationship as we deliver the highest quality of care to your children. If you have no dental insurance benefits, we ask that you pay for services at the time of the visit. If you have dental benefits, we ask that you bring all necessary insurance information so that we can "estimate" your portion to pay at the time of visit. Those with dual insurance benefits need to be aware that does not always mean 100% coverage. You may be responsible for deductibles and services not covered by either policy. It is also important for you to know that there are many insurance plans in America. This being said, it is impossible for our office to know the precise covered benefits of your insurance plan. It is your responsibility, as parents, to know and understand the policies and benefits of your insurance. If you have any questions or concerns, please do not hesitate to ask, we are here to assist you in any way we can.**