Cody Dental Group. *Established 1946*

Pediatric Patient Information Form

Welcome, and thank you for coming to our office! How did you hear about our office? Please circle
Magazine 5280 / Internet / Referral __________________ / Yellow pages / Facebook. / Other_______
Are other family members patients of Cody Dental Group? Yes / No

Patient Name____Date of Birth____________________

Parent's Name: Mother_________________________________Father______________________________
Number of brothers and sisters______________________ School Attending_________________________

In case of EMERGENCY, we are to contact:_________________________Ph #________________________

Send Account Statements to: ____
Address____

Parental Status:

Mother/Father/Guardian
Married __Widow__Separated__Divorced__Single__

Address:__________________________
____
____

Phone: Cell________________________
Home______________________
Work_______________________

Occupation:________________________
Company Name:_____________________
Address:__________________________
____

Social Security #_____________________

Insurance Company__________________
Address___________________________
____

Phone#____________________________
Group or ID #_______________________
DOB_______________________________
Email______________________________

Mother/Father/Guardian
Married__Widow__Separated__Divorced__Single__

Address:______________________________
____
____

Phone: Cell____________________________
Home__________________________
Work___________________________

Occupation:_____________________________
Company Name:_________________________
Address:______________________________
____

Social Security#________________________

Insurance Company______________________
Address______________________________
____

Phone#________________________________
Group or ID#___________________________
DOB__________________________________
Email_________________________________

Release of Dental Examination/Treatment Information
Assignment of Insurance Benefits, and
Disclosure of Finance Charge on overdue accounts.
Authorization for Credit Check.

1. I take full responsibility for the account. If the amount which will be paid by insurance is important in determining the choice of treatment, I will find out this information before starting treatment.
2. I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that the dentist will use the information to determine appropriate dental treatment. If there is any change in the child's medical status, I will inform the dentist.
3. In requesting examination and/or treatment on or after this date, I authorize the release of all information (including x-rays) relating to such examination or treatment to any health service plan or insurance company from which benefits have been paid or may be payable.
4. I also authorize the release of such information to any peer review committee of the state or local associations which may request it.
5. I hereby authorize payment directly to Dr Patra Watana, DMD of the group insurance benefits otherwise payable to me, but not to exceed his/her actual charges for the covered services rendered. I authorize the use of this signature on all insurance submissions. I understand that any overpayment caused by my previous personal payment will be promptly refunded by me. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurances.
6. I understand that interest-free monthly payment arrangements may be made. I also understand that if no monthly payment arrangements have been made, amounts for which more than one monthly statement has been sent will be subject 1 ½ % per month (18% Annual; percentage rate) finance charge.

Payment is due at the time of treatment unless prior arrangements have been approved.

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Parent or Guardian Signature   Date

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Doctor Signature   Date

Dr Patra Watana, DMD
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