Macomb
children's dentistry

WELCOME TO OUR PRACTICE

ABOUT YOUR CHILD

Patient's First name_____ Last name_____
Name child would like to be called _____
Date of birth_____ ☐ Male ☐ Female
Who will be financially responsible for account?_____
Mother and Father of child: ☐ Married ☐ Separated ☐ Divorced

How did you hear about our office?_____

PERSON(S) RESPONSIBLE FOR ACCOUNT

Mother's Information: ☐ Mother ☐ Step-Mother ☐ Legal Guardian

Name:	Date of Birth:	Occupation:
Address:	SS#:	Employer:
City, State, Zip:	Marital Status:	Does your Child live with you? Y N
Home #:	Cell #:	Work #:
Email Address:		

Fathers's Information: ☐ Father ☐ Step-Father ☐ Legal Guardian

Name:	Date of Birth:	Occupation:
Address:	SS#:	Employer:
City, State, Zip:	Marital Status:	Does your Child live with you? Y N
Home #:	Cell #:	Work #:
Email Address:		

DENTAL INSURANCE INFORMATION

Primary Dental Insurance company: _____

Subscriber name _____ Subscriber ID # _____

Group # _____ Insurance company phone # _____

Secondary Dental Insurance company: _____

Subscriber name _____ Subscriber ID # _____

Group # _____ Insurance company phone # _____

AUTHORIZATION

*I authorize dental diagnostic procedures to be performed by Dr. Amit Batra and his staff. *I understand it is my responsibility to inform Macomb Children's Dentistry of any changes to my child's medical status *I assign directly to Macomb Children's Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payments of benefits.

Parent/Guardian Signature_____ Date: _____