Today's Date:______/______/______Name:____

Male Female Child's Date of Birth:____/____/____

Address:______________________________City:____________________State:____Zip:_______

Parent's Home P#:_____________ Parent's Work Ph#:______________Parent's Cell #:____________

Parent's E mail:___________________________________ FT / PT Patient- College Student

(College/Univ-Name/Town/State of College):____

Who referred you? **Refer a Friend** **_________________________________** **Yellow Book**

DEX Phone Book **Internet ··GOOGLE or other?**____________

Emergency Contact: Name: __________________ Relationship:__________________

Who accompanied minor patient today?____

PARENTAL/GUARDIAN INFORMATION:

Father's/Guardian's Name:

Mother's/Guardian's Name:

____

____

Address: (if different from patient's)

Address: (if different from patient's)

____

____

____

____

H #________ W#________ cell #__________

H #_________ W #________ Cell#__________

SS#:___/___/___, D.O.B.____/____/____ SS#: ____/____/____, D.O.B. ___/____/____

Employer:___________________________

Employer:____________________________

DENTAL INSURANCE: Y/N? primary? Y/N? DENTAL INSURANCE: Y/N? primary Y/N?

Ins Company Name:_____________________ Insurance Company Name:__________________

Gr#:_____________________________

Gr#:_________________________________

CONSENT FOR TREATMENT:

I being the parent or guardian of_________________________ do hereby request and authorize the

Name of Minor Child

the dental staff to perform necessary dental services for my child, including, but not limited to x rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge. I understand that providing accurate information regarding my health allows Brink Street Dental, Ltd. to treat me effectively and safely. I understand that I am financially responsible for all charges whether they are covered by insurance or not. I understand that I will be consulted as to all recommended treatment and alternatives before treatment is provided.

__/___/___/

x____

Date: Signature of Insured/Guardian:

ASSIGNMENT OF BENEFITS TO INSURANCE:

I, the undersigned, have dental insurance coverage and request assignment of benefits to Dr. David Niles of Brink Street Dental, Ltd. I understand that the information given will be held in strict confidence. I hereby authorize the doctor to release all information necessary to secure the payment of benefits unless revoked. I authorize the signature on all insurance submission whether manual or electronic:

_ /___/___/___ x__________________

______________ ____________________Date:

Signature of Insured: