



**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient's Address: \_\_\_\_\_  
Street City State Zip

**FATHER'S INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
D.O.B. \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone :( ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

**MOTHER'S INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
D.O.B. \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone :( ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

1. Name of Policy Holder: \_\_\_\_\_
2. Marital Status: Single Married Separated Divorced Widowed
3. Insurance Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_
4. Policy Holder's Employer: \_\_\_\_\_
5. Policy Holder's Social Security number \_\_\_\_\_
6. Policy Holder's Date of Birth: \_\_\_\_\_
7. Insurance Group Number: \_\_\_\_\_ Identification Number: \_\_\_\_\_
8. Insurance Company's Phone Number: \_\_\_\_\_

- We will be happy to give you a super bill that you may mail to your secondary insurance company

In order to control the cost of dental services, we require that payment be made at the time of service, unless otherwise discussed previously with our Financial Coordinator. Payment can be made with cash, personal check, MasterCard, Visa, Discover, American Express or Care Credit. If for any reason your check is returned to us, there will be an additional fee. **Initial** \_\_\_\_\_

We must be notified of any cancellations at least 24 hours prior to the appointment. The office reserves the right to charge a \$50 fee for a broken appointment. **Initial** \_\_\_\_\_

I authorize release of any information relating to this claim and the right to charge \$25 if my account goes to WPDG's collection agency. I understand that I am responsible for all costs of dental treatment. **Initial** \_\_\_\_\_

→ \_\_\_\_\_  
Signed (Patient, Parent if Minor) Date

Westfield Pediatric Dental Group

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

\* You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_