Eldorado Dental- Child

Patient Information

Patient Name: _____Preferred Name: _____
◯MALE ◯FEMALE
Social Security #: _____ Birth Date: _____

Phone (Home): _____ Phone (Cell):_____

Address:_____ City:_____ Zip:_____

Parent/Guardian Name: _____ Parent Phone#_____

Can we thank anyone for referring you? _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

Insurance Information

Name of Insured: _____ Is the insured a patient? ◯Yes ◯No

Patient's relationship to insured: ◯Self ◯Child ◯Other _____

Insured's Birth Date: _____ID #:_____ SS#_____
Group # _____

Dental insurance company name: _____

Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. Every effort will be made to help me with my insurance, but I understand my insurance company may not pay as expected; I will be fully responsible for remaining amount owed. **DELINQUENT ACCOUNTS will be referred for collections after 30 days and subject to credit reporting. You will be responsible for the collection fees/attorney fees.**

I hereby authorize payment directly to Eldorado Dental, Tony Reyes DDS, from group insurance benefits otherwise payable to me. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian_____

Date: _____