**Southfield Kids Dentist, PLLC**
17550 W. 11 Mile Rd. SUITE B
Lathrup Village, MI 48076
Office: (248) 565 - 3332
Fax: (248) 552 - 0992

(Please Print Legibly)

Today's date:

## PATIENT INFORMATION

| Child's last name: | First: | Middle: |
|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Nick Name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security #: | Home phone no.: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Mother's Last Name/First Name/ Initial | Marital Status: | Email Address: | Mother's Phone # ( ) |
|---|---|---|---|
| Father's Last Name/First Name/ Initial | Marital Status: | Email Address: | Father's Phone # ( ) |

Who may we thank for referring you? We would like to thank them: ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

## INSURANCE INFORMATION

(Please give your insurance card or insurance info. to the receptionist.)

| Person responsible for Bill: | Birth Date: / / | Address (if different): | Home phone # : ( ) |
|---|---|---|---|

Is this person present today? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone # : ( ) |
|---|---|---|---|

Please indicate primary insurance ❑ PPO ❑ HMO ❑ EPO ❑ State Medicaid

| Subscriber's name: | Subscriber's S.S #: | Birth Date: / / | Group # : | Policy # : |
|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group # : | Policy # : |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## LANGUAGE

Languages Spoken by Patient/Family: ❑ English ❑ Spanish ❑ Arabic ❑ Other :

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dental practice. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*