Trussville Pediatric Dentistry
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Trussville, Al. 35173
(205) 655-1000
office@trussvillepediatricdentistry.com

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD, THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name_____Preferred Name_____Age_____

Sex_____Race_____Date of Birth_____Patient's School_____Social Security#_____

Patient's Adress_____
Street City State Zip

Phone Number/Email for confirmation of Appt._____**Email**_____

Primary Dental Coverage_____Insured'sName_____DOB_____Martial Status_____

Where Employed_____Group#_____Policy#_____

Social Security#_____Relationship to Child_____

Secondary Dental Coverage_____Insured's Name_____DOB_____Martial Status_____

Where Employed_____Group#_____Policy#_____

Social Security#_____Relationship to Child_____

Father's Name_____DOB_____Social Security #_____

His Address_____Phone#_____
Street City State Zip

Where Employed_____Phone#_____

Mother's Name_____DOB_____Social Security#_____

Her Address_____Phone#_____
Street City State Zip

Where Employed_____Phone#_____

Other children in the family_____

Account Information: Person ultimately responsible for account:

Name_____Relationship to Child_____

Billing Address_____ _____

Social Security#_____Drivers License#_____Phone#_____

_____(Intials)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.