Pediatric Dentistry Registration
nancy kwon hsieh, DDS, MS

Child's Name: _____ Nickname _____ DOB_____ Sex M/F
Name & age of siblings _____ Was your child adopted? Y/N
Who may we thank for referring you to us?_____

General Information

Father/Guardian's name _____ SS No. _____ DOB_____
Mother/Guardian's name _____ SS No. _____ DOB_____
Single ____ Married ____ Divorced _____ Child resides with: Both parents ____ Mother _____ Father _____

Home address _____Home Phone No. _____
Father/Guardian employer _____W Phone No. _____
Business address _____Cell No. _____

Mother/Guardian employer _____Phone No. _____
Business address _____Cell No. _____
Email address _____

Person financially responsible for child's dental care _____Main Contact Phone No._____
Relative not living with you (name, address & phone)_____
_____

The permission of a parent or guardian is necessary for dental treatment of a minor. I give the dentist permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand, a late charge of 1.5 % per month, and a monthly charge of $10.00 will be added to unpaid balances over 60 days past due and where appropriate, credit bureau reports may be obtained.

SIGNATURE _____ Relationship _____ Date _____

Insurance Information

Do you have dental insurance coverage for this child? Y/N

Primary Insurance
Name of Policy Holder _____ ID# _____ Group No. _____
Insurance Company _____ Phone No. _____ Address _____

Is your child covered under more than one plan? Y / N

*** The coordination of primary and secondary insurance is determined by a strict set of guidelines. While we are happy to file your secondary insurance claims for you, we ask that you provide accurate information on your coverage. Errors or omissions may lead to the incorrect filing of claims which may delay payment and may be considered insurance fraud.

Secondary Insurance (Primary and Secondary insurances are determined by parent's month of birth.)
Name of Policy Holder _____ ID# _____ Group No. _____
Insurance Company _____ Phone No. _____ Address _____

I hereby authorize payment to the above named dentist of the group dental benefits, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization.

SIGNATURE _____ Relationship _____ Date _____