Cody Dental Group. *Established 1946*

Pediatric Patient Information Form

Welcome, and thank you for coming to our office! How did you hear about our office? Please circle
Magazine 5280 / Internet / Referral _____ / Yellow pages / Facebook. / Other_____
Are other family members patients of Cody Dental Group? Yes / No

Patient Name_____Date of Birth_____

Parent's Name: Mother_____Father_____
Number of brothers and sisters_____ School Attending_____

In case of EMERGENCY, we are to contact:_____Ph #_____

Send Account Statements to: _____
Address_____

Parental Status:

Mother/Father/Guardian	Mother/Father/Guardian
Married __Widow__Separated__Divorced__Single__	Married__Widow__Separated__Divorced__Single__
Address:_____	Address:_____
_____	_____
_____	_____
Phone: Cell_____	Phone: Cell_____
Home_____	Home_____
Work_____	Work_____
Occupation:_____	Occupation:_____
Company Name:_____	Company Name:_____
Address:_____	Address:_____
_____	_____
Social Security #_____	Social Security#_____
Insurance Company_____	Insurance Company_____
Address_____	Address_____
_____	_____
Phone#_____	Phone#_____
Group or ID #_____	Group or ID#_____
DOB_____	DOB_____
Email_____	Email_____

Release of Dental Examination/Treatment Information
Assignment of Insurance Benefits, and
Disclosure of Finance Charge on overdue accounts.
Authorization for Credit Check.

1. I take full responsibility for the account. If the amount which will be paid by insurance is important in determining the choice of treatment, I will find out this information before starting treatment.
2. I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that the dentist will use the information to determine appropriate dental treatment. If there is any change in the child's medical status, I will inform the dentist.
3. In requesting examination and/or treatment on or after this date, I authorize the release of all information (including x-rays) relating to such examination or treatment to any health service plan or insurance company from which benefits have been paid or may be payable.
4. I also authorize the release of such information to any peer review committee of the state or local associations which may request it.
5. I hereby authorize payment directly to Dr Patra Watana, DMD of the group insurance benefits otherwise payable to me, but not to exceed his/her actual charges for the covered services rendered. I authorize the use of this signature on all insurance submissions. I understand that any overpayment caused by my previous personal payment will be promptly refunded by me. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurances.
6. I understand that interest-free monthly payment arrangements may be made. I also understand that if no monthly payment arrangements have been made, amounts for which more than one monthly statement has been sent will be subject 1 ½ % per month (18% Annual; percentage rate) finance charge.

Payment is due at the time of treatment unless prior arrangements have been approved.

_____

Parent or Guardian Signature Date

_____

Doctor Signature Date

Dr Patra Watana, DMD
4301 East Amherst Avenue * Denver, Colorado. 80222 * (303)753-7497 * www.codydental.com