Beach Kids DENTISTRY
A Division of Atlantic Dental Care, PLC

New Patient Social And Insurance Information

This record is confidential and for use only within this office.

Patient Information

Patient Name ______________________ Preferred Name ______________________

Birth Sex: ❑ Male ❑ Female Current Gender Identity: __________ Race/Ethnicity: ________________ Date of Birth __________ Age____

Address ______________________ City ________________ State ________Zip____________

Best Contact Phone ______________________ School________________ Grade________________

Whom does the child live with? ____

How did you hear about our practice? ____

Guardian Information

Name ______________________ Relationship to Patient __________ Date of Birth ________________

Address ______________________ City ________________ State ________Zip____________

SSN________________ Home Phone ________________ Work Phone ________________ Cell Phone ________________

Email ______________________ Employer ______________________

Name ______________________ Relationship to Patient __________ Date of Birth ________________

Address ______________________ City ________________ State ________Zip____________

SSN________________ Home Phone ________________ Work Phone ________________ Cell Phone ________________

Email ______________________ Employer ______________________

Name ______________________ Relationship to Patient __________ Date of Birth ________________

Address ______________________ City ________________ State ________Zip____________

SSN________________ Home Phone ________________ Work Phone ________________ Cell Phone ________________

Email ______________________ Employer ______________________

Name ______________________ Relationship to Patient __________ Date of Birth ________________

Address ______________________ City ________________ State ________Zip____________

SSN________________ Home Phone ________________ Work Phone ________________ Cell Phone ________________

Email ______________________ Employer ______________________

Does your child have a Medicaid/State-Issued plan? ❑ YES ❑ NO

Dental Insurance Information: Primary

Subscriber ______________________ Relationship to Patient __________ Date of Birth ________________

Employer ______________________ Group# ________________ SSN or ID#* ________________

Insurance Provider ________________ Ins. Phone ________________ Ins. Address________________

Dental Insurance Information: Secondary

Subscriber ______________________ Relationship to Patient __________ Date of Birth ________________

Employer ______________________ Group# ________________ SSN or ID#* ________________

Insurance Provider ________________ Ins. Phone ________________ Ins. Address________________

Authorization To Treat

I, being the parent or guardian of the above minor patient, hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures the dentist may deem necessary during treatment. I understand that the dentist and designated assistants treating the above patient will use restorative, oral surgery, and patient management techniques that are reasonable, necessary, and advisable. I authorize the administration of anesthetics or analgesics which may be deemed advisable by the dentist. I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the Initial examination and the extent of dental pathology. I grant permission to use clinical photographs In scientific Journals and lectures.

I accept responsibility for full payment of all dental services performed on the above-named patient. The parent or guardian bringing the patient to our office Is responsible for payment of the account. Insurance co-payments are due at the time of service. The Insurance will be filed promptly, but the remaining account balance must be paid In full within 30 days, regardless of whether the insurance company has paid or not. Delinquent accounts over 60 days will Incur 1.5% per month finance charge. If the account is referred for collection, the parent or guardian will be responsible for the balance plus the attorney's fees which is 25% of the remaining balance.

Signature of parent/guardian ______________________________ Date ________________