Palouse Pediatric Dentistry
Karen M. Sept, DMD

New Patient Information

Child's Name _____ Nickname _____

DOB: ___/___/_____ Male____ Female____

Responsible Party Information

MOTHER/GUARDIAN

Name_____ Home Phone_____Cell Phone_____

Spouse Name_____Cell Phone_____

Address_____City_____State____Zip_____

Email Address_____

Mother's Employer_____ Address_____

Mother's Social Security Number_____-_____-_____ Mother's DOB_____/_____/_____

FATHER/GUARDIAN

Name_____ Home Phone_____Cell Phone_____

Spouse Name_____Cell Phone_____

Address_____City_____State____Zip_____

Email Address_____

Father's Employer_____ Address_____

Father's Social Security Number_____-_____-_____ Father's DOB_____/_____/_____

EMERGENCY CONTACT

Name_____ Phone Number(s)_____

CHILD'S INSURANCE (***Please document insurance coverage in addition to the following on the reverse of this form***)

Dental Insurance Company that Covers the Child _____

Subscriber's Name _____ Date of Birth _____/_____/_____

Group Number _____ ID Number _____

Has any other immediate family member been treated in this office? _____

How did you hear about our practice? _____

I authorize my insurance benefits to be paid to Dr. Karen Sept. I also authorize Dr. Karen Sept to release any information required for all insurance claims.
I acknowledge that I am financially responsible for all charges whether or not they are paid by insurance. If I desire credit to be extended to me and/or my family for services rendered, I am aware that a credit report may be obtained before credit is extended

Signed_____ Date_____/_____/_____

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Additional Insurance Coverage

SECONDARY INSURANCE

Dental Insurance Company that Covers the Child _____

Subscriber's Name _____ Date of Birth _____/_____/_____

Group Number _____ ID Number _____

TERTIARY INSURANCE

Dental Insurance Company that Covers the Child _____

Subscriber's Name _____ Date of Birth _____/_____/_____

Group Number _____ ID Number _____