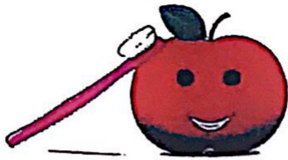

Carolyn A. Loughlin, D.D.S.

Diplomate, American Board of Pediatric Dentistry

Healthy Young Smiles

Patient Information

Patient: ______________________________ Today's Date: ____________________________

Nickname/Preferred Name: ___________________ Date of Birth: ___________ Age:_____ Sex: M F

School: _____________________________ Grade: ___________________

Home Address:___________________________ City: _____________________ Zip: _____________

Phone Number: ___________________________ Social Security Number: ____________________

How do you think your child will respond to dental treatment? ____

Reason for today's visit: ____

E-mail Address: ____

May we contact you via email or text for appointment reminders and/or account statements? yes no

Parent/Guardian

Name:________________________________ Date of Birth: ______________ Social Security #:______-______-________

Occupation: ____________________________ Employer: _____________________ Driver's License #: _______________

Home Phone: ___________________________ Work Phone: ___________________ Cell Phone: ____________________

Parent/Guardian

Name:________________________________ Date of Birth: ______________ Social Security #:______-______-________

Occupation: ____________________________ Employer: _____________________ Driver's License #:: _______________

Home Phone: ___________________________ Work Phone: ___________________ Cell Phone: ____________________

Financial and Insurance Information

INSURANCE INFORMATION

Dental Insurance Company: ____________________________ Phone: _____________________

Name of Insured: ______________________________________ ID#: _______________________ DOB: ____________

Group/Policy #: ___________________________________ Employer:___________________________________

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is due at each appointment.

____Cash ____Personal Check ____Visa ____MasterCard ____Discover

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners, I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependant's behalf.

I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorney/s fees. Incurred in such collection efforts.

Signature of Parent or Guardian ____ Date ___________________________

Scanned with CamScanner