Poiset and Associates

Pediatric Dentistry and Orthodontics

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Orthodontics 858-810-7387
www.poisetandassociates.com

Child's Name: _____ Today's Date: _____

Whom may we thank for referring you? Medical Doctor_____ Dentist_____ Family/Friend_____ Other_____

Parent's Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Name:_____ Relationship to Child:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Driver's License #: _____ State: _____ Occupation: _____

Employer Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Parent's Dentist:_____

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Parent's Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Name:_____ Relationship to Child:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Driver's License #: _____ State: _____ Occupation: _____

Employer Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Parent's Dentist:

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Insurance Information

PRIMARY INSURANCE

Name of Insured: _____

Address (if different from above):_____

City:_____ State: _____ Zip:_____

Date of Birth:_____/_____/_____

Social Security #:_____-_____-_____

Insurance ID #:_____ Group/Plan #:_____

Name of Employer:_____

Name of insurance Company:_____

Phone # - Insurance Company:(____)_____

SECONDARY INSURANCE

Name of Insured: _____

Address (if different from above):_____

City:_____ State:_____ Zip:_____

Date of Birth:_____/_____/_____

Social Security #:_____-_____-_____

Insurance ID #:_____ Group/Plan #:_____

Name of Employer:_____

Name of insurance Company:_____

Phone # - Insurance Company:(____)_____

Financial Responsibility and Assignment of Benefits

I understand that I am financially responsible for all dental treatment and medications provided to my child. I understand that my insurance carrier may pay less than the actual bill for services provided to my child. I understand that I am responsible for all charges whether or not they are paid for by my insurance carrier. I assign directly to Poiset and Associates all dental benefits otherwise payable to me for services rendered to my child.

I understand that a finance charge of 0.83% per month will be added to all balances over 90 days. If legal action and/or assignment to an attorney or collection agency should become necessary to collect my account, I agree to pay all cost of collection including court costs, collection agency commissions and cost, and reasonable attorney fees.

_____

Parent/Guardian Signature Date

Notices of Privacy Practices

I have reviewed the document entitled "Notice of Privacy Practices" for Poiset and Associates. I understand and agree with the content of this document, specially paragraph 1A.

_____

Parent/Guardian Signature Date

Authorization to Release Health Information

I authorize the doctors and staff of Poiset and Associates to obtain, use and disclose my child's Protected Health Information to carry out treatment, payment activities and healthcare operations. This information will include but is not limited to my child's health history, diagnostic records, diagnosis and treatment provided.

_____

Parent/Guardian Date