Children's Dental Center of SE Iowa
409 Layne Drive
West Burlington, IA 52655
Phone: (319) 752-1444 Fax: (319) 752-8468 E-mail: cdental@live.com

Date _____

Patient Information

Patient Name _____
SSN _____ Date of Birth _____ Gender: Male or Female
Mailing Address _____
City _____ State _____ ZIP Code _____
Home Phone _____
To Whom May We Release Information? (Other Parent, etc.) _____
_____
Whom May We Thank for Referring You? _____

Responsible Party

Parent/Guardian Responsible for Patient _____
Relationship to Patient _____ Date of Birth _____ SSN _____
E-mail Address _____
Home Phone _____ Cell Phone _____
Mailing Address (if different from above) _____
City _____ State _____ ZIP Code _____
Employer _____ Work Phone _____

Dental Insurance Information

Policyholder Name _____ Relationship to Patient _____
Date of Birth _____ SSN _____
Employer _____ Employer Phone _____
Address of Employer _____
City _____ State _____ ZIP Code _____
Insurance Company _____ Insurance Phone _____
Address _____
City _____ State _____ ZIP Code _____
Policy Number _____ Group Number _____

Do you have additional dental insurance? Yes or No (If yes, please complete the information on the back of this page.)

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and/or dental practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance

benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Parent/Guardian Signature: _____

Secondary Dental Insurance Information

Policyholder Name _____ Relationship to Patient _____
Date of Birth _____ SSN _____
Employer _____
Address of Employer _____
City _____ State _____ ZIP Code _____
Insurance Company _____ Phone _____
Address _____
City _____ State _____ ZIP Code _____
Policy Number _____ Group Number _____