



Dr. Jody Morse & Dr. Michael Doyle

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Child Information

CH#

Date:

Full Name _____ Preferred name _____
Male/Female _____ Age _____ Birthdate _____ Social Security # _____
School _____ Grade _____
Hobbies/Sports _____

Mother's Name _____ Birthdate _____ SS# _____
Address _____
Home Phone _____ Business Phone _____ Cell phone _____
Occupation _____ Employer _____ City/State _____
Father's Name _____ Birthdate _____ SS# _____
Address (if different from child) _____
Home Phone _____ Business Phone _____ Cell Phone _____
Occupation _____ Employer _____ City/State _____

By whom were you referred? _____

Family members we have seen _____

Dental Insurance Co _____ Group# _____ Policy# _____

This is: Mother's policy Father's policy

I authorize the release of any information relating to dental claims required by my insurance companies. I authorize payment directly to this office, of the insurance benefits otherwise payable to me. This authorization is valid until rescinded in writing or replaced by one of a later date.

PAYMENT for services is due in full at the time of service. If there is a balance after an insurance claim is received your payment is due within 15 days from our invoice date. All returned checks are subject to a \$25.00 fee and the account will be changed to C.O.D. or prepaid.

I understand that I am ultimately responsible for all costs of dental treatment. I understand and authorize that the doctor and/or qualified staff will perform the diagnostic/preventative/restorative services deemed necessary for me, and authorize release of any information to other healthcare providers. I have answered these questions to the best of my ability, and will **notify the office of any changes** in this information at the earliest possible time.

Thank you very much for the opportunity to serve you. Patients like you are responsible for our growth and we never forget that fact. If you ever have a question regarding your account, or if for some reason you're not satisfied, do not hesitate to let us know.

Signature _____ Date _____