Parent/Legal Guardian Information:

Father:_____
Address:_____
_____
Home Phone: ( )_____-_____
Work Phone: ( )_____-_____
Cell Phone: ( )_____-_____
E-mail address:_____
SSN: _____-_____-_____Birthday: _____/_____/_____
Parents are: Married_____ Divorced_____ Single_____ Widowed_____ Partners_____ Other_____
Child lives with:_____Name of person financially responsible for treatment:_____

Employer: _____
Occupation:_____
Dental insurance provided by this employer? Y____ N____
Insurance Company Name:_____
Insurance Company Phone: ( )_____-_____
Group #:_____Union Local #_____
Member ID:_____

Additional Primary Caregiver (Optional):
Name:_____
Relationship to child:_____
Phone: ( ) _____-_____

Mother:_____
Address:_____
_____
Home Phone: ( )_____-_____
Work Phone: ( )_____-_____
Cell Phone: ( )_____-_____
E-mail address:_____
SSN: _____-_____-_____Birthday: _____/_____/_____

Employer: _____
Occupation:_____
Insurance provided through this employer? Y_____ N_____
Insurance Company Name:_____
Insurance Company Phone: ( )_____-_____
Group #:_____Union Local #_____
Member ID:_____

Emergency Contact:
Name:_____
Relationship to child:_____
Phone: ( ) _____-_____

Multiple Patient Family: complete guardian & insurance info provided on sibling registration form (name):_____
Permission for the office of Dr. Patrick Creevan to use e-mail & cell phone as a means of communication: Initial _____

Authorization and Acknowledgement:

The persmission of a parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in Dr. Patrick C. Creevan's professional judgement to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status or contact information. I have also received a copy of "The Facts About Fillings" as required by law.

SIGNATURE:_____ **Print Name:**_____
Relationship to Patient:_____ **Date:** _____/_____/_____

Financial Agreement:

For patients with dental insurance:I hereby authorize the dentist to release any information including diagnosis and records to the third party payor and/or other health care practitioners. I authorize and request my insurace to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization, I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services; and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information, including the SSN of the party completing these forms. You are required to pay your portion on the day of treatment; without a SSN payment is required in full; we will provide you with the competed claim to mail, directing any insurance reimbursements to the policyholder.
For patients without insurance: Payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services.
and where appropriate, a credit bureau report may be obtained.
You may opt to receive a statement of your account balance, payable within 30 days of services rendered, however, you must provide a social security number. This policy may be subject to change depending on timely account payment.
A $75 missed appointment fee may be charged to your account for appointments that are missed or cancelled with less than 24 hours notice.

SIGNATURE:_____ **Print Name:**_____
Relationship to Patient:_____ **Date:** _____/_____/_____

For Office Use Only:
____Medical/Dental history reviewed verbally with parent/guardian for above patient
Signature_____ Date:_____/_____/_____