PATIENT DATE SHEET (MINOR)

ESTIMATED PORTIONS NOT COVERED BY INSURANCE ARE DUE AT TIME OF TREATMENT.

METHOD OF PAYMENT:

CASH_____CHECK_____CREDIT CARD_____

HAVE YOU BEEN A PATIENT OF DR. GEARING PREVIOUSLY? YES_____NO_____

CHILD'S NAME_____BIRTHDATE_____

ADDRESS_____CITY_____ZIP_____

SCHOOL ATTENDING_____CITY_____ZIP_____

MOTHER'S NAME_____BIRTHDATE_____SS#_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____CELL PHONE_____

DENTAL INSURANCE YES____NO____

INSURANCE NAME_____GROUP #_____

EMPLOYER_____

FATHER'S NAME_____BIRTHDATE_____SS#_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____CELL PHONE_____

DENTAL INSURANCE YES____NO____

INSURANCE NAME_____GROUP #_____

EMPLOYER_____

REFERRED TO OUR OFFICE BY DR_____

NEAREST RELATIVE_____PHONE_____

I certify all the above information is true and complete and I am the patient or authorized representative of the patient. I authorize all required information to my insurance company as necessary to process any claims and authorize my insurance company to pay directly to the provider. A service fee will be charged on all returned checks. If the account is placed with an attorney and/or collection agency, reasonable costs and/or legal fees shall be borne by the undersigned. All patient information is held in confidence. Any patient information no longer needed by this office will be shredded and disposed of properly.

WOULD YOU LIKE FEES DISCUSSED BEFORE TREATMENT? YES____NO____

SIGNED_____DATE_____

RELATIONSHIP TO CHILD_____