NEW PATIENT INFORMATION

Child's Name _____ Date of last dental visit_____

Name child goes by _____ Who was your child's last dentist_____

Sex_____ Birth date_____ Have we seen other children in your family? _____

How do you think your child will do in our office? _____ How did you hear about our office?

_____ ☐ PHONE BOOK ☐ MAILER ☐ FRIEND ☐ DENTIST

Reason for visit _____ OTHER _____

GENERAL INFORMATION

This information is requested for financial and credit purposes

Father	**Mother**
Full name_____	Full name _____
Date of birth _____	Date of birth_____
Home address_____ City_____	Home address_____ City _____
State/ZIP_____ Home Phone_____	State/ZIP_____ Home Phone _____
Employer_____ Work Phone_____	Employer_____ Work Phone _____
SSN #_____ Cell Phone _____	SSN #_____ Cell Phone _____

Name of person who is financially responsible for payment _____

Name of nearest relative not living with you _____

Their address/city_____Home phone_____Work phone_____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Policy holder's name _____	Policy holder's name_____
Name of insurance carrier _____	Name of insurance carrier_____
Address _____	Address _____
Phone number of Insurance company (___)_____	Phone number of Insurance company (___)_____
Group/Policy No._____Union Local_____	Group/Policy No._____Union Local _____

As a courtesy to you, we will file your insurance for your dental claims.

I authorize Doctor Jensen and his staff to furnish my insurance company with all information to process my dental claims. I authorize the above named insurance company to pay all benefits due me directly to Doctor Jensen. I understand that I am financially responsible for all charges and those costs not covered by my insurance company WILL BE DUE AT THE TIME TREATMENT IS RENDERED*. I understand that a credit history may be obtained. The debtor agrees to pay all collection costs including reasonable attorney's fees and interest, and agrees that the debt is due and payable in Utah County, State of Utah.*

Any claim or controversy between the patient and/or legal authorized representative of the patient and dentist concerning the care and treatment or the quality of dental services rendered by the dentist to the patient shall be resolved by mediation or arbitration. A claim or controversy shall first be submitted to non-binding mediation. If the claim or controversy is not resolved to the satisfaction of both parties through the mediation process, it will be submitted to binding arbitration. Judgment(s) on the decision achieved through mediation or rendered by the arbitrator(s) can be entered in any court having jurisdiction thereof. Costs for mediation and or arbitration services shall be shared equally by the parties involved. The foregoing mediation/arbitration agreement does not pertain to actions taken for the collection of debts owed as a result of dental services rendered.

To the best of my knowledge this information is true and correct and I agree to all of the preceding terms.

_____ _____

Parent/Legal Guardian Signature Date