MINOR PATIENT'S PARENT INFORMATION

Patient Name: _____ **Birth Date:** _____ **Date:** _____

*Information Regarding Parents of Minor Patient		
	MOTHER	**FATHER**
First Name:		
Last Name:		
Middle Name:		
Address – Street:		
City, State, Zip		
Home Phone #:		
Cell Phone #:		
Social Security #:		
Date of Birth:		
Employer:		
Employer Phone #:		
Street Address:		
City, State, Zip		

Insurance Information

Primary Insurance Name: Group # (Plan, Local or Policy #):

Dental Coverage? ○Yes ○No Orthodontic Coverage? ○Yes ○No

Phone #: _____

Ins. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____

Insured's Birth date: _____ Insured's Employer: _____

Insured's ID #: _____ Relation: _____

Secondary Insurance Name: Group # (Plan, Local or Policy #):

Dental Coverage? ○Yes ○No Orthodontic Coverage? ○Yes ○No

Phone #: _____

Ins. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____

Insured's Birth date: _____ Insured's Employer: _____

Insured's ID #: _____ Relation: _____

Disclosure statement for minors:

I hereby authorize Plum Grove Dental Associates to treat my minor daughter/son,

_____ (Minor's Name)

Signed: _____

Who is Responsible for Payment on this account? _____ **Date:** _____