

IF YOU HAVE PREVIOUSLY COMPLETED THIS FORM FOR ANOTHER CHILD, PLEASE GIVE THAT CHILD'S NAME AND OMIT THE REMAINING QUESTIONS UNLESS THERE HAVE BEEN ANY CHANGES.
 OTHER CHILD'S NAME: _____, AND PLEASE SIGN AT THE BOTTOM.

FAMILY INFORMATION

RESIDENCE ADDRESS	STREET	CITY	ZIP CODE	PHONE
FATHER'S NAME	ADDRESS & PHONE # IF DIFFERENT			OCCUPATION
EMPLOYED BY	BUSINESS ADDRESS			BUSINESS PHONE
MOTHER'S NAME	ADDRESS & PHONE # IF DIFFERENT			OCCUPATION
EMPLOYED BY	BUSINESS ADDRESS			BUSINESS PHONE
MOTHER'S CELL PHONE	NAMES & AGES OF ALL BROTHERS AND SISTERS			
FATHER'S CELL PHONE				

AUTHORIZATION & INSURANCE INFORMATION

IS YOUR CHILD COVERED BY A DENTAL PLAN? YES NO

HAS YOUR CHILD RECEIVED PREVIOUS DENTAL CARE UNDER THIS PLAN? YES NO

NAME OF PARENT INSURED	SOCIAL SECURITY #	NAME OF INSURANCE COMPANY
DATE OF BIRTH	CDL #	GROUP OR POLICY #
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IF BOTH PARENTS ARE INSURED, MOST INSURANCE COMPANIES USE THE BIRTHDAY RULE TO DETERMINE WHICH INDIVIDUAL HAS THE PRIMARY AND SECONDARY INSURANCE COVERAGE. THE PARENT WHOSE BIRTHDAY FALLS EARLIEST IN THE YEAR IS USUALLY THE PRIMARY INSURED.

IF PARENTS ARE DIVORCED, SINGLE OR SEPARATED, WHO HAS LEGAL AUTHORITY TO SIGN A CONSENT FOR MEDICAL AND DENTAL TREATMENT?

NAME	RELATIONSHIP	NAME	RELATIONSHIP

Assignment of benefits: I hereby authorize payment of the insurance benefits, otherwise payable to me directly to David H. Okawachi, DDS, Inc. I understand that I am financially responsible for any charges not covered by my insurance. I authorize release of any information for filing of dental insurance claims.

SIGNATURE: _____ RELATIONSHIP TO CHILD _____ DATE _____

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever any change in my child's health or if my child's medicines change, I will inform the office at the next appointment without fail. I hereby authorize David H. Okawachi, DDS, Inc. and his dental auxiliaries to perform any and all treatment for my aforesaid child and consent to such methods, drugs and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled.

SIGNATURE: _____ RELATIONSHIP TO CHILD _____ DATE _____

For office use only:

- | | |
|---|---|
| <input type="checkbox"/> Informed Consent | <input type="checkbox"/> Behavior Consent |
| <input type="checkbox"/> Anesthesia Consent | <input type="checkbox"/> Financial Policy |
| <input type="checkbox"/> DMFS | <input type="checkbox"/> HIPPA |