# GUARDIAN AND INSURANCE INFORMATION

Please list the names and dates of birth of your children: _____
_____

Parent/Guardian Information ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Guardian ☐Other _____
Name:_____ Preferred Name:_____ Date of Birth:_____
Address: _____ City:_____ State: _____ Zip: _____
Home Phone:_____ Cell Phone:_____ Primary Contact? ☐Yes ☐No
Employer: _____Occupation: _____
Work Phone:_____ Email: _____
Is this person legally responsible for the health care decisions for child/children listed above? ☐Yes ☐No

Parent/Guardian Information ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Guardian ☐Other _____
Name:_____ Preferred Name:_____ Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____ Primary Contact? ☐Yes ☐No
Employer:_____ Occupation:_____
Work Phone:_____ Email: _____
Is this person legally responsible for the health care decisions for child/children listed above? ☐Yes ☐No

Please list anyone who may accompany your child/children to an appointment and has permission to make decisions concerning their dental treatment: _____
_____

What is the preferred method of contact? ☐Phone ☐Email ☐Text ☐Other _____
Do you authorize Kitfox Pediatric Dentistry to contact you via e-mail and text message? ☐Yes ☐No

**Insurance Information (If Applicable)**
Person Who Carries Insurance: _____ Date of Birth: _____
SS#:_____ Relationship to Patient:_____
Employer:_____ Insurance Company Name: _____
Insurance Company Address: _____
City:_____ State:_____ Zip:_____ Phone: _____
Group#: _____ Policy#: _____ Member ID#: _____

Insurance information: Dental benefits differ greatly from traditional health insurance. Dental insurance is never a "pay all" solution, but merely an aid. Many plans tell their patients, "services will be covered at 100%, 80%, or 50%," but do not clearly specify plan fee allowances, annual maximums and limitations. It is more realistic to expect some out of pocket expense to be incurred with most visits to our office. In some cases, your benefits have specific limitations based on the number or frequency of services your plan will cover. Dr. Akins may ask for x-rays or diagnostic aids more frequently than your annual benefits allow. We provide exceptional dentistry, and the treatment recommended for your child will be based on what is best for your child's dental health – not on what your insurance may or may not cover.

To the extent permitted by law, I consent to the use and disclosure of my child's protected health information by Kitfox Pediatric Dentistry to carry out payment activities in connection with this claim or to determine benefits, or to determine the benefits for related services.

Guardian's Signature:_____Date:_____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law. I hereby authorize and assign directly to Kitfox Pediatric Dentistry payment of the dental benefits otherwise payable to me directly. This assignment will remain in effect until I cancel it in writing. I understand that I am responsible for any portion of my bill not covered by insurance.

Guardian's Signature:_____Date:_____