TAYLOR BROOK DENTAL ASSOCIATES, P.A.
MINOR PATIENT DATA SHEET

Last Name	**First Name**	**Middle Initial**	**Date of Birth**

There are many changes that can occur between visits to Taylor Brook Dental Associates. We have found that updating the information of minor patients upon each visit to TBDA has helped to alleviate problems with changes in legal guardians, responsible parties, or the ability for TBDA to discuss the dental care of said minor patient with the appropriate parties.

Primary Legal Responsible Party Address:

Name:_____
Street/PO Box:_____
City:_____
State:_____ Zip:_____
Home Phone:_____
Work Phone:_____
Mobile Phone:_____
Email:_____

Secondary Legal Responsible Party (if applicable):

Name:_____
Street/PO Box:_____
City:_____
State:_____ Zip:_____
Home Phone:_____
Work Phone:_____
Mobile Phone:_____
Email:_____

*Please note that TBDA will only add/bill the Primary Responsible Party. It is their responsibility to copy and share bills/medical information as needed with other parties.

I authorize TBDA to send medical information to insurers and providers outside of the practice when necessary, to obtain payment for treatment rendered and for continuity of care.	I give permission to TBDA to leave medical information on voice mail if unavailable.	**Social Security Number** _____-_____-_____
☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female

INSURANCE INFORMATION

Please Note: WE ARE UNABLE TO ACCEPT MAINE CARE

Does the minor patient you have dental insurance: ☐ No ☐ Yes

There have been no changes to the insurance coverage since my last visit: ☐

Payment is expected in full at time of service. Patients with dental insurance are expected to pay any co-payment at the time of service. Finance charges of 1.5% per month will be charged on all past due accounts. We accept all major credit cards, checks and cash.

_____ _____
Patient/Guardian Signature Date

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In order to bill your insurance company the following **MUST** be completed in **FULL**.

Regarding the Policy Holder:

Name:_____
Employer:_____
Street/PO Box:_____
City:_____
State:_____ Zip:_____
Date of Birth:_____
Social Security Number:_____

Regarding the Insurance Company:

Ins. Co. Name:_____
Ins. Co. Street:_____
Ins. Co. City:_____
Ins. Co. State:_____ Zip:_____
Policy/Certificate Number:_____
Group Number:_____
Effective from _____(date) to _____(date)

Please list all patients covered by this policy (First and Last Names):

_____ _____

_____ _____