

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:

Secondary Legal Responsible Party (if applicable):

Name: _____

Name: _____

Street/PO Box: _____

Street/PO Box: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Mobile Phone: _____

Mobile Phone: _____

Email: _____

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. <input type="checkbox"/> Yes <input type="checkbox"/> No	I give permission to TBDA to leave medical information on voice mail if unavailable. <input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; padding: 10px; margin: 0 auto; width: 80%;"> <p>Social Security Number</p> <p>_____ - ____ - ____</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> </div>
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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:

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

Regarding the Policy Holder:

Regarding the Insurance Company:

Name: _____

Ins. Co. Name: _____

Employer: _____

Ins. Co. Street: _____

Street/PO Box: _____

Ins. Co. City: _____

City: _____

Ins. Co. State: _____ Zip: _____

State: _____ Zip: _____

Policy/Certificate Number: _____

Date of Birth: _____

Group Number: _____

Social Security Number: _____

Effective from _____ (date) to _____ (date)

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

- **We cannot guarantee that your insurance will cover any procedure.**
- **You are responsible for your insurance coverage, their practices and any unpaid balance.**

PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE

- Our office files insurance benefits as a courtesy to you.
- All deductibles, copayments, and non-covered fees are due at the time of service.

I understand that Taylor Brook Dental Associates cannot guarantee insurance coverage. I understand that I am responsible for any unpaid balance not covered by insurance. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to TBDA all insurance payments otherwise payable to me. I understand that I am responsible for the full balance.

Finance charges of 1.5% per month will be charged on all past due accounts. We accept cash, checks, Visa, MasterCard, Discover, and American Express.

Date: _____

Signature of Patient, Parent, or Guardian (Financially Responsible Party)

Printed Name of person signing

Patient Name (if different)