

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.

## VALLEY PEDIATRIC DENTISTS, P.C.

6239 E. Brown Road, Suite 102 • Mesa, Arizona 85205 • (480) 396-3660  
16611 S. 40th Street, Suite 150 • Phoenix, AZ 85048 • (480) 753-3711

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### Patient Information

Name \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Child's Physician: \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

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### Responsible Party Information (Parenting Adult)

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthday \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthday \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Business Phone \_\_\_\_\_ Address \_\_\_\_\_ Business Phone \_\_\_\_\_

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### Dental Insurance Information

Subscriber's Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Billing Address \_\_\_\_\_ Group # \_\_\_\_\_ I.D. # \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Phone \_\_\_\_\_

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### Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorized my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

• Please fill out our medical history on reverse side •

