SW PDX PEDIATRIC DENTISTRY

Dr. Melissa J. Wages, DDS

General Information

(Guardian 1) Name: _____ DOB: _____
Street Address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Employer: _____ Work Phone: _____
Occupation: _____ Social Security #: _____
Dental Insurance Company: _____ Group #: _____
Insurance Company Address: _____

(Guardian 2) Name: _____ DOB: _____
Street Address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Employer: _____ Work Phone: _____
Occupation: _____ Social Security #: _____
Dental Insurance Company: _____ Group #: _____
Insurance Company Address: _____

Emergency Contact (Friend or Relative)

_____
Name Phone Number Address Relationship to Child

_____
Name Phone Number Address Relationship to Child

Please list your children below:
Name: _____ Sex: _____ DOB: _____
Name: _____ Sex: _____ DOB: _____
Name: _____ Sex: _____ DOB: _____
Name: _____ Sex: _____ DOB: _____
Name: _____ Sex: _____ DOB: _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of the account, the signer agrees to pay for all costs and expenses including reasonable attorney fees. I authorize payment directly to SW PDX Pediatric Dentistry for all dental benefits otherwise payable to me. A service charge of 1.5% will be charged on all accounts after 60 days.

_____ _____
Signature of Parent/Guardian Date