

Personal Intake Form

Names of Legal Guardians

1. Name of Legal Guardian: (First and Last):
2. Name of Legal Guardian: (First and Last):

_____ Attach a copy of DL

I am the Legal Guardian for the children named below:

Child's Name:	Date of Birth
Child's Name:	Date of Birth
Child's Name:	Date of Birth
Child's Name:	Date of Birth
Child's Name:	Date of Birth

Please list anyone who you give permission to bring your child to their appointment.

Please check either Yes or No if you give the individual permission to receive information and the rights to sign for medical history, consents & routine dental treatment (hyperlink #1).

Name	Yes _____	No _____
Name:	Yes _____	No _____
Name:	Yes _____	No _____
Name:	Yes _____	No _____

Address and Contact Information (*at least one must be a cell phone number for confirmations*)

Home street address:
City, State, Zip Code:

Preferred phone number for confirmations

Cell phone number:
Secondary phone number:
Email (NEEDED FOR CONFIRMATIONS):

Insurance Information:

For Commercial Insurance:

Policy Holder:
Policy Holders DOB:
Policy Holders ID# / SS#:
Policy Holders Employer:
Insurance Company:

For Medicaid Insurance:

Patient Name:

Patient DOB:

Patient Medicaid ID #:

____ Attached copy of insurance card

Please initial beside each statement your acknowledgement and consent

_____ I am certifying that the information listed is complete and accurate

_____ I am the legal guardian of the children identified above

_____ I give the staff of Coastal Kids Dental & Braces permission to take photos of my child for medical records

_____ I have read and understand the Privacy Act Document (Hyperlink #2)

_____ I have read and understand CKD office policies (Hyperlink #3)

_____ I will be responsible for any fees not covered by my insurance (Hyperlink to How Insurance Works)

_____ I have read and agree to the Insurance Disclaimer for Medicaid insurance (Hyperlink #5)

Signature of Legal Guardian:

Date: