kids first
DENTAL GROUP
Laura J. Donlan, DDS
7314 N. Willowlake Ct. Suite D • Peoria, IL. 61614
Ph. 309-692-0175

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Primary Contact Person: _____ Relationship to Patient: _____

Preferred Contact#: _____ Mom Cell#: _____ Dad Cell#: _____

MOM address (*if different than above*): _____

City: _____ State: _____ Zip: _____

DAD address (*if different than above*): _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

(please complete **ONLY** for that parent which carries dental insurance):

PRIMARY: Mom / Dad -- Employer _____ Dental Carrier _____

**** DO YOU HAVE ACTIVE DENTAL INSURANCE THROUGH THIS EMPLOYER? Y / N**

SECONDARY: Mom / Dad -- Employer _____ Dental Carrier _____

**** DO YOU HAVE ACTIVE DENTAL INSURANCE THROUGH THIS EMPLOYER? Y / N**

MEDICAL INFORMATION:

Allergies: _____ Current Medication: _____

Changes in medical history: **Y/N --** Explain: _____

I have reviewed the questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child, and I agree to notify the dentist if any changes in my child's health status occur.

I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submission.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. I will be responsible for any charges not paid by my insurer within 90 days of my first statement & all my expenses which may incur in connection with efforts to collect the charges.

In the event we must enforce our rights under this Agreement after your failure to pay all charges due within 90 days of our first statement, you must pay all charges to include collection agency fees, which are typically 33% to 50% of the unpaid balance, reporter's fees, for depositions and at trial expenses we incur in enforcing our rights under this Agreement. Also, in the event that you have not paid all charges due within 90 days of our first statement, a finance charges will begin to accrue at the rate of eighteen percent, 18% per annum. I also agree to release all necessary information in order for the collection agency to reach me. This authorization will remain in effect until revoked by me in writing.

Signature of parent of guardian: _____ Date: _____

Payment is due in full at the time of treatment, unless prior arrangements have been approved.