Galbraith Mountain
PEDIATRIC DENTISTRY

3300 SQUALICUM PARKWAY SUITE 200, BELLINGHAM, WA 98225 (360) 733-7708

PATIENT INFORMATION

Today's Date_____

Child's Name: _____
LAST FIRST M.I.

Date of Birth:_____

Child's Nickname:_____ ❑ Boy ❑ Girl

Child's Home Phone # :(_____) _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Child's Address: _____
mailing address if different from above

_____
CITY STATE ZIP

Referred by:_____

Who can we call for you in case of an emergency?

_____
Name Relationship Phone#

INSURANCE

Primary Dental Insurance

Insured Person's Name: _____

Insurance Co: _____

Ins. Co. Address _____

_____
CITY STATE ZIP

INS. CO. PHONE # _____

Insured's SS# _____

or ID# _____ Group#_____

Insured's Date of Birth: _____

Insured's Employer: _____

Is Patient Covered by another Carrier? ☐ Yes ☐ No

Secondary Dental Insurance

Insured Name: _____

Insurance Co.: _____

Ins. Co. Address _____

_____
CITY STATE ZIP

INS. CO. PHONE # _____

Insured's SS# _____

or ID# _____

Group #: _____

Insured's Date of Birth: _____

Insured's Employer: _____

I hereby authorize and request my insurance company to pay directly to the Doctor the amount(s) due on my claim for services rendered to my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference, and if the treatment is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.
Payment is due at each visit. I understand that any fees incurred will be my responsibility and I will keep my account current.

_____
SIGNATURE DATE

PERSON RESPONSIBLE FOR PAYMENT

Who is accompanying this child today?

_____
FULL NAME RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

Please list other family members treated here:

_____

_____

Mother's Name: _____
☐ STEP MOTHER ☐ GUARDIAN

❑ Married ❑ Single ❑ Divorced ❑ Widowed

_____
(❑ Check if same as child's) HOME ADDRESS

_____
CITY STATE ZIP

( ) ( )
HOME PHONE # WORK PHONE # EXT.

( )
CELL PHONE # EMAIL:

_____ _____
MOTHER'S SOCIAL SECURITY # MOTHER'S DATE OF BIRTH

Employer: _____ How Long? _____

Father's Name: _____
☐ STEP FATHER ☐ GUARDIAN

❑ Married ❑ Single ❑ Divorced ❑ Widowed

_____
(❑ Check if same as child's) HOME ADDRESS

_____
CITY STATE ZIP

( ) ( )
HOME PHONE # WORK PHONE # EXT.

( )
CELL PHONE # EMAIL:

_____ _____
FATHER'S SOCIAL SECURITY # FATHER'S DATE OF BIRTH

Employer: _____ How Long? _____

*** For children of divorced parents, the parent or caretaker bringing the child in shall be responsible for all fees for services provided on that date.**

LEGAL GUARDIAN

Date: _____

I, _____, the parent or legal guardian of my child, _____. authorize and consent to routine and emergency dental treatment for my child when deemed necessary by qualified personnel at the practice of Chad Galbraith, D.D.S, P.S. This authorization will be in affect until revoked in writing by me.

_____
(signature of parent/guardian)