WELCOME TO DR. PETER D. WENDELL'S ORTHODONTIC OFFICE

Child Form

Child's Name _____
Last First MI

I prefer to be called _____
Child's birthday____/____/____ Age ___ Male __ Female __
Email Address _____
School _____
Hobbies/Sports _____
Child's Home # _____ Cell Phone # _____
Child's Address _____
City _____ State ___ Zip _____

General Dentist_____

Who is accompanying the child?_____
Do you have legal custody of this child? ___yes ___no
Whom do we thank for referring you? _____
Other Siblings/Ages _____
_____
Family Members seen by us _____
_____

Parents Information

Who is responsible for account? _____ Parent's Marital Status: __Single __Married __Widowed __Divorced __ Separated

__Father __Step Father __Guardian
Name _____Birthday__/__/__
Address(If different than child's) Hm# _____
Street _____
City _____State__ZipCode _____
SS# _____
Wk# _____Ext____ Cell# _____
Email _____
Employer _____
Occupation _____
Employer Address _____
City _____State___Zip _____

__Mother __Step Mother __ Guardian
Name _____Birthday __/__/__
Address (if different than child's) Hm# _____
Street _____
City _____State __ZipCode _____
SS# _____
Wk# _____Ext____Cell# _____
Email _____
Employer _____
Occupation _____
Employer Address _____
City _____State___Zip _____

Orthodontic Insurance Only

If father has Orthodontic Insurance Coverage for the child, Please fill out below:
Insurance Company _____
Insurance Address _____
City _____State__Zip_____
Insurance Ph# _____
Insured's ID#_____Group#_____

If mother has Orthodontic Insurance Coverage for the child, Please fill out below:
Insurance Company _____
Insurance Address _____
City_____State___Zip_____
Insurance Ph# _____
Insured's ID#_____Group#_____

Authorization

This office reserves the right to verify the credit status of potential patients and or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of Parent or Guardian Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Signature of Parent or Guardian Date

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.