Amanda N. Siu, D.D.S.
Board Certified Pediatric Dentist

Welcome to our practice! Thank you for providing the information requested below. Today's Date: _____

Tell Us About Your Child

Child's Name: _____ Nickname: _____ Gender: _____
Social Security: _____ Age: _____Date of Birth: _____Birthplace: _____
Child's Home Address: _____
Is your child adopted?
Who may we thank for referring you?_____
What is the primary reason for today's visit? _____

Parent Information

Parent's Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed ☐Partnered ☐Separated

Parent #1 Information

Name: _____ Date of Birth: _____ SS#: _____ Driver's License #: _____
Address: _____
Street City State Zip
Home #:_____ Cell #: _____Work #: _____ Email: _____
Employer: _____ Occupation: _____
Responsible for account ☐ Responsible for appointments ☐

Parent # _ Information

Name: _____ Date of Birth: _____ SS#: _____ Driver's License #: _____
Address: _____
Street City State Zip
Home #:_____ Cell #: _____Work #: _____ Email: _____
Employer: _____ Occupation: _____
Responsible for account ☐ Responsible for appointments ☐

Insurance Information

Primary Dental Insurance

Insurance Company Name: _____ Phone #: _____ Group #: _____
Insurance CompanyAddress_____
PO Box/Street City State Zip
Policy Owner's Name: _____ Relationship to Patient: _____
Policy Owner's Date of Birth: _____ SS#: _____
Policy Owner's Employer: _____
Employer's Address: _____
PO Box/Street City State Zip

Secondary Dental Insurance

Insurance Company Name: _____ Phone #: _____ Group #: _____
Insurance CompanyAddress_____
PO Box/Street City State Zip
Policy Owner's Name: _____ Relationship to Patient: _____
Policy Owner's Date of Birth: _____ SS#: _____
Policy Owner's Employer: _____
Employer's Address: _____
PO Box/Street City State Zip

Authorization and Release

I certify that the information I have given above is correct to the best of my knowledge. I will not hold the dentist or any member of the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and/or their health practitioners. I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclousure of my child's Protected Health Information to carry out treatment, payment activities, and healthcare operations.

Patient / Guardian Printed Name: _____ Patient / Guardian Signature: _____ Date: _____