Dr. John Gennantonio • Dr. Katie Stewart
Dr. Sarah Husted
Diplomat, American Board of Pediatric Dentistry

Sea of Smiles
Pediatric Dentistry

Patient Name	❑ Male ❑ Female	Date of Birth

Address _____ City _____

State _____ Zip _____ Home Phone _____

Email Address _____

Child's School _____ Sibling Names _____

Hobbies _____

Mother's Name _____ Mother's Cell Phone _____

Mother's S.S. No. _____ Mother's D.O.B. _____ Employed By _____

Father's Name _____ Father's Cell Phone _____

Father's S.S. No. _____ Father's D.O.B. _____ Employed By _____

How did you hear about our office? _____

In order to expedite your dental claim, the section(s) below must be filled out completely.

PRIMARY DENTAL INSURANCE

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Social Security Number _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Member ID _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

Insurance Company Phone Number _____

SECONDARY DENTAL INSURANCE ❑ N/A

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Social Security Number _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Member ID _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

Insurance Company Phone Number _____

In case of emergency, please list the name, phone number and relationship to the patient not living at home:

_____

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any/and all necessary dental services be rendered. Authorization is hereby granted for Sea of Smiles to provide dental care for this child. Furthermore, I acknowledge receipt of the office policy as to charges and payments and agree to comply. I will be financially responsible for the charges incurred for the dental treatment of this child.

Signature of Parent/Guardian _____ **Relationship to Patient** _____

Print Name _____ **Date** _____