



Glenn V. Hemberger, DDS, MS

Dental Speciality for Children and Teens



PATIENT INFORMATION SHEET

YOUR CHILD

Child's Name _____
First Middle Last

Age _____ Sex _____ Birthdate _____

Nickname _____ SS# _____

School _____

Child's Home Address _____

Phone _____

RESPONSIBLE PARTY

Name _____

Relationship _____

Address _____

SS# _____ DL# _____

Who is responsible for making appointments? _____

PARENT OR GUARDIAN INFORMATION

Mother Stepmother Guardian

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

Employer _____

Occupation _____

Address _____

SS# _____ DOB _____

Marital Status: Single Married Separated
 Divorced Widowed

Father Stepfather Guardian

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

Employer _____

Occupation _____

Address _____

SS# _____ DOB _____

Marital Status: Single Married Separated
 Divorced Widowed

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment.

*Cash *Check *Visa *MasterCard *American Express *Discover

Who may we thank for referring you to our office? _____

Purpose of this visit _____

In case of Emergency - name of nearest relative or friend _____
 _____ phone _____

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment be performed by Dr. Glenn V. Hemberger.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment. This consent for treatment shall remain in full force and effective until cancelled by either party. Such cancellation must be in writing and in no way relinquishes responsibility of a current balance. Furthermore, I will be responsible for any bill incurred on this child for dental treatment.

Signed _____

Date _____

OFFICE POLICY IS PAYMENT AT TIME OF SERVICE

