Pediatric Dentistry of Spartanburg

"Building Bright Smiles for the Future"

(864) 574-4287 www.carolinakidzdental.com

Please complete the following questions. We are required to update our patient files every six months.

GENERAL INFORMATION:

Child's Full Name_____ Preferred Name_____

Mailing Address_____ City/State/Zip_____

Date of Birth_____ Age_____ SS#_____ Male or Female (circle one)

Child's Physician_____ Physician's Phone: _____

Home Phone: _____ Cell Phone: _____

Do you receive text messages? Yes or No

**Parents Email Address_____

***Has there been any change in your general health within the past year? Yes or No (circle one)

If Yes, Please Explain_____

_____

Please list any MEDICATIONS you are currently taking: _____

Preferred Dentist (Circle One) Dr. H.J. Turner Dr. Jensen Turner No Preference

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Please answer the following questions. (Circle One)

1. *Do you have dental coverage through Medicaid?* *YES or NO*
   If yes, what is the Medicaid ID number? _____

2. *Has your dental insurance coverage changed in the last six months?* *YES or NO*
   If yes, please complete the following:
   *Name of Employee*_____ *Name of Employer*_____
   Employee's SS# _____ *Employee's Date of Birth*_____
   (Please provide a copy of insurance card)

3. *Do you have secondary dental insurance?* *YES or NO*
   If yes, please complete the following:
   *Name of Employee*_____ *Name or Employer*_____
   Employee's SS# _____ *Employee's Date of Birth*_____
   *Insurance Co.*_____
   (Please provide a copy of insurance card)

INSURANCE IS FILED AS A PROFESSIONAL COURTESY TO YOU.
We file your insurance based on what you provide, please make sure all insurance information is current
Deductibles and co-pays are due at each appointment.

For your convenience we accept:

CASH PERSONAL CHECK CREDIT CARD: Visa MasterCard Discover Debit Card

*SIGNATURE*_____*DATE*_____