DANIEL A. CRAWFORD, D.D.S.
LAUREN F. WALLACE, D.D.S.

# Pediatric Dental Partners

SHANNON M. BACKOFEN, D.D.S.
SUSAN L. CHIDLOW, D.D.S.

**SHREVEPORT OFFICE**
318 Carroll Street
Shreveport, Louisiana 71105
(318) 865-2250

**BOSSIER CITY OFFICE**
4001 Viking Drive, Suite A
Bossier City, LA 71111
(318) 747-7020

**IMPORTANT**** **PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST**

**PATIENT INFORMATION:**
**Your kindness In furnishing the following Information will be appreciated.**

First Name _____ Middle Name _____ Last Name _____
Street Address _____
City _____ State _____ Zip Code _____
Phone # _____ Cell # _____ Phone # to confirm appts. _____
Sex _____ Date of birth _____ /_____ /_____ School _____
Child's physician or pediatrician _____
Have any of your children been seen in this office? _____Yes _____No Names _____
Whom may we thank for referring you to this office? _____

**GENERAL INFORMATION**
Father's Name _____ Soc. Sec. No. _____
Mother's Name_____ Soc. Sec. No. _____
Home Address _____ City_____ State _____ Zip _____
Mailing Address if different _____
Father's home phone (  ) _____ Mother's home phone (  ) _____
Father's Place of Employment _____ Business Phone _____
Mother's Place of Employment_____ Business Phone _____
In case of emergency contact _____ Phone _____

**RESPONSIBLE PARTY**
First Name _____ Middle Name _____ Last Name _____
Street Address _____
City _____ State _____ Zip Code _____
Phone Number (  ) _____ Work Number (  ) _____
Employer _____ Occupation _____
Sex _____ Date of birth _____ /_____ /_____ Soc. Sec. No. _____
Relationship to patient _____
Parent's marital status: Married (  ) Separated (  ) Divorced (  ) Widowed (  ) Single (  )

**INSURANCE INFORMATION**
Is patient covered under a dental insurance plan?_____ If so, please complete the following portion.
Insurance Company Name _____
Address _____ City_____ State _____ Zip _____
Phone Number_____
Group Number _____ Policy Number_____
Policyholder/Claimant _____

**PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

I, the undersigned, authorize payment of dental benefits to Pediatric Dental Partners, for any services furnished by them. I understand I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning dental care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims of benefits.

Date _____ Signed _____
We request the first visit be paid by you. This usually will satisfy part or all of your deductible.