JAMES M. COOPER D.D.S.

Minor Patient Information

Date_____

Patient Name_____ Preferred Name_____

Date of Birth _____ **Male or Female** Lives With_____

Address_____

Home Phone_____ Cell Phone_____

Where/Whom Would you Like us to Confirm Appointment _____

Father's Name:_____ D.O.B._____ SS#_____

Cell Phone_____ Work Phone_____

E-mail_____ Employed By_____

Mother's Name_____ D.O.B._____ SS#_____

Cell Phone_____ Work Phone_____

E-mail_____ Employed By _____

Address for Billing _____

_____

AUTHORIZATION/SIGNATURE ON FILE

I hereby authorize treatment and authorize the provider to release medical information necessary to submit claims to my insurance company, to provide necessary information to the insurers and appeal claims on behalf of myself. I understand and agree that a copy of this authorization and/or assignment of benefit, when signed by me, or an authorized representative, may be sent to my insurance company. I understand that I am financially responsible for all charges not covered by insurance. I understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____

Signature Date

_____

Signature Date