



Dear Parent or Guardian:

You have filled out a form sent home by your child's school for the "Help A Child Smile" mobile dental program. Below is a form to provide further information that is needed to schedule your child for our services. Please complete and sign this form, or we will not be able to see your child at his/her school.

When this form has been completed and signed, return it to our office by fax at (770) 760-8055 or mail to, "Help a Child Smile" 1806 Over Lake Dr, SE Conyers, GA 30013. If you have any questions, please feel free to call our office at (770) 760-7900, ext. 128 or toll free at (800) 770-0388. Thank You.

(PLEASE PRINT)

Today's Date: / /	Name of School:	County:
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PATIENT INFORMATION

**Please show child's name as it appears on his/her dental insurance card*

Child's Last Name:		First:	M.I.:
Preferred Name:	Date of Birth: / /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Other Family Members Seen Here:			
Person Responsible for the Bill:			
Address if Different from the Child's:			
Home Phone: ()	Work Phone: ()	Cell Phone: ()	

PRIMARY POLICY HOLDER INFORMATION

Policy Holder's Last Name:		First:	M.I.:
Date of Birth: / /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No: / /	
Patient's Relationship to Insured:		Employer:	

PRIMARY INSURANCE INFORMATION

Insurance Company:		Group No.:	
Insurance Address:	City:	State:	Zip:
Insurance Phone No.: ()	Insurance Policy No.:		

SECONDARY POLICY HOLDER INFORMATION

Policy Holder's Last Name:		First:	M.I.:
Date of Birth: / /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No: / /	
Relationship to Primary Insured:		Employer:	

SECONDARY INSURANCE INFORMATION

Insurance Company:		Group No.:	
Insurance Address:	City:	State:	Zip:
Insurance Phone No.: ()	Insurance Policy No.:		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that my deductible and/or estimated co-payment will need to be paid prior to treatment and that I am financially responsible for any remaining balance. I also authorize "Help A Child Smile", or my insurance company, to release any information required to process my claims.

Patient/Guardian Signature: _____