

Just Kids, Inc.  
Family Information

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Address (if different) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Father's Name \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Address (if different) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Primary Insurance: \_\_\_\_\_

Group# \_\_\_\_\_ ID Number: \_\_\_\_\_

Name of Insured / Employee: \_\_\_\_\_

Secondary Insurance : \_\_\_\_\_

Group# \_\_\_\_\_ ID Number: \_\_\_\_\_

Name of Insured / Employee: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for recommending Just Kids, Inc.? \_\_\_\_\_

**I hereby authorize my insurance company to make payment directly to Just Kids, Inc., and authorize release of any necessary and pertinent documents. As the parent/legal guardian of a minor patient, I hereby agree to accept financial responsibility for dental treatment provided by Just Kids, Inc. I acknowledge that I am financially responsible for all charges whether or not paid by insurance. There is no interest or finance charge on current accounts. After 60 days, all accounts are subject to a Finance Charge of 1 ½ % of the unpaid balance (or a minimum charge of 50 cents).**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date