



**HOLLYWOOD CHILDREN'S DENTISTRY
GENERAL INFORMATION**

Parent Name _____

DOB _____ SSN (required) _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Employer _____ Occupation _____

Parent's Dental Insurance Company _____

Insurance Company Address _____

Insurance Company Phone Number _____

Group Number _____

Member ID Number _____

Parent Name _____

DOB _____ SSN (required) _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Employer _____ Occupation _____

Parent's Dental Insurance Company _____

Insurance Company Address _____

Insurance Company Phone Number _____

Group Number _____

Member ID Number _____

Name and phone number of the nearest friend or relative in case of emergency

Whom may we thank for recommending our office? _____

I hereby authorize my insurance company to make payment directly to Hollywood Children's Dentistry, and authorize release of any necessary and pertinent documents.

(signature)

(date)