BRADY AND CRIST DENTISTS, INC.

8116 TIMBERLAKE ROAD
LYNCHBURG, VA 24502

CHILD INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SEX: M / F DATE OF BIRTH _____ SOCIAL SECURITY # _____

SCHOOL _____ HOME PHONE # _____

FATHER INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ EMAIL _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

MOTHER INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ EMAIL _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

WHO, NOT LIVING WITH YOU, SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

NAME _____ PHONE # _____

I HEREBY AUTHORIZE TREATMENT AND THE OFFICE OF BRADY AND CRIST DENTISTS, INC. TO RELEASE DENTAL INFORMATION REQUIRED IN THE COURSE OF EXAMINATION AND TREATMENT AND PERMIT PAYMENT DIRECTLY TO THEM BENEFITS DUE FOR THEIR SERVICES RENDERED. I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE. THIS INCLUDES BUT IS NOT LIMITED TO CO-INSURANCE, CO-PAYMENT, DEDUCTIBLES AND NON-COVERED SERVICES. RETURNED CHECKS AND BALANCES OLDER THAN 30 DAYS WILL BE SUBJECT TO ADDITIONAL FEES AND INTEREST OF 1.5% PER MONTH. IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO COLLECT AN UNPAID BALANCE DUE FOR DENTAL SERVICES RENDERED TO ME OR MY FAMILY, I/WE AGREE TO PAY THE ATTORNEY'S FEE OF 33 1/3% AND OTHER SUCH COSTS AS THE COURT DETERMINES PROPER. I UNDERSTAND THAT I MAY BE CHARGED A FEE FOR LAST MINUTE CANCELLATION OR NO-SHOW FOR MY APPOINTED TIME.

SIGNATURE _____ DATE _____

(PARENT AND/OR GUARDIAN IF MINOR)

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

INSURED/EMPLOYEE NAME _____ INSURED I.D. # _____

EMPLOYEE DATE OF BIRTH _____

PATIENT'S RELATIONSHIP TO EMPLOYEE _____