

**CRAIG R. CAMERON, DDS, PLC**  
**CHILD/MINOR REGISTRATION**  
(Confidential)

DATE: \_\_\_\_\_

**PATIENT INFORMATION**

Name of Minor Child \_\_\_\_\_  
Last Name First Name Initial  
Sex \_\_\_M\_\_\_F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Nickname \_\_\_\_\_  
Home Address \_\_\_\_\_  
Street City State Zip  
Person Financially Responsible \_\_\_\_\_  
Billing Address \_\_\_\_\_  
Street City State Zip  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

**PRIMARY DENTAL INSURANCE INFORMATION**

Subscriber Name \_\_\_\_\_  
Last Name First Name Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (if different from patients) \_\_\_\_\_  
City State Zip  
Subscriber Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Subscriber Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

**SECONDARY DENTAL INSURANCE INFORMATION**

Subscriber Name \_\_\_\_\_  
Last Name First Name Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (if different from patients) \_\_\_\_\_  
City State Zip  
Subscriber Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Subscriber Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

**EMERGENCY CONTACT**

In the event of an emergency, whom should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

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**INSURANCE ASSIGNMENTS**

If this office is unable to accept your insurance company's assignment, it does not absolve the patient of full responsibility for the charges in full for treatment rendered. The estimate provided by this office is considered as a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. The agreed upon payment plan for the patient's estimated portion must be kept current or the assignment will be cancelled and the full amount will become due and payable. Claims are submitted promptly after treatment is rendered, and if not paid by patient's insurance company by the 91<sup>st</sup> day after treatment, will be billed in full to the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer your questions.

I, the undersigned, have insurance with \_\_\_\_\_  
Name of Insurance Company

And assign directly to Dr. Craig R. Cameron all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

\_\_\_\_\_  
Signature of Insured/Guardian

**FINANCIAL AGREEMENT**

Be advised the policy of this office is interest of 1.5% per month (18% ANNUAL PECENTAGE RATE) will be applied to all accounts over 60 days.

I, acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

\_\_\_\_\_  
Signature of Insured/Guardian

**MINOR/CHILD CONSENT**

I, being the parent or guardian of \_\_\_\_\_ do hereby request and  
Name of minor/child

authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

\_\_\_\_\_  
Signature of Insured/Guardian