everyone by one

pediatric dentistry

PATIENT REGISTRATION FORM

YOUR CHILD'S / CHILDREN'S FULL NAME(S):	BIRTHDAY	AGE	GENDER
			M / F
			M / F
			M / F
			M / F

FAMILY INFORMATION

PARENT / LEGAL GUARDIAN	PARENT / LEGAL GUARDIAN
NAME:	NAME:
Address:	Address:
City, State, Zip	City, State, Zip
Cell Phone:	Cell Phone:
Home Phone:	Home Phone:
Date of Birth:	Date of Birth:
Email:	**Email:**

DENTAL INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber Name:	Subscriber Name:
Name of Insurance:	Name of Insurance:
Insurance Phone #:	Insurance Phone #:
Group #: ID#:	Group #: ID #:
Employer:	Employer:

How did you hear about us? (Insurance Listing / Another Patient / Friend / Coworker / Community Resource / Social Media / Online Search / Google / Yelp)

EBO accepts most dental insurance plans. For your convenience, we send a dental claim to your insurance plan electronically the day your child receives treatment. Your insurance company is obligated to pay the claim within 60 days from the date of submission. At that point, we consider the outstanding charges billable to you, the consumer. You will be sent a statement showing the unpaid claims and/or your financial responsibility after all claims have been processed by your insurance provider. **I understand that I am responsible for any charges that are reasonably denied by my insurance company. By signing below, you consent to your child's treatment and your financial obligation to Everyone By One.**

Parent/Legal Guardian Signature Date

Please email form to business@everyonebyone.com or fax to 425-451-4029