John R. Liu, DDS
SallySue M. Lombardi, DDS, MSD
Donna J. Quinby, DMD, MSD

NEW PATIENT INFORMATION

Eastside Pediatric Dental Group
185 NE Gilman Blvd
Issaquah, WA 98027
425 392 4048

CHILD'S NAME NICKNAME

DATE OF BIRTH AGE GENDER □M □ F □

HOME ADDRESS

HOME PHONE MOBILE PHONE Preferred □ H □ M

SCHOOL

EMAIL ADDRESS

BROTHERS SISTERS

NAME OF PHYSICIAN PHONE

PURPOSE OF TODAY'S VISIT

WHO MAY WE THANK FOR REFERRING YOU?

WHO IS FINANCIALLY RESPONSIBLE?

Mother's/Guardian's Name		Father's/Guardian's Name	
Mother's Date of Birth		Father's Date of Birth	
Address if different from above		Address if different from above	
Work phone	Cell phone	Work phone	Cell phone
Social Security Number		Social Security Number	
Are you the insurance carrier?		Are you the insurance carrier?	
Insurance Company		Insurance Company	
Subscriber ID		Subscriber ID	
Group #		Group #	
Insurance address		Insurance address	
Insurance phone #		Insurance phone #	

EMERGENCY CONTACT (other than parents)		
NAME	RELATIONSHIP	PHONE

I authorize the dental team to perform the necessary dental services for my minor/child. I understand that I am financially responsible for all fees, regardless of any insurance coverage in place. I certify that if my child has insurance coverage, I assign, directly, to EPDG all insurance benefits, if any, otherwise payable to me for services rendered. I, hereby, authorize EPDG to release all information necessary to secure the payment of these benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____ _____

Signature of person completing form Relationship or patient Date