R. CARSON KIGHT, DMD
DISTINCTIVE DENTISTRY

Child's Information

Date: _____

Child's Full Name: _____

Nickname: _____ Age: _____ Date of Birth: _____ M/F: _____

Other Siblings Coming to this Office: _____

In Case of Emergency (Other than Parent):

1) _____ Phone #: _____ Cell #: _____

2) _____ Phone #: _____ Cell #: _____

Financial Information

Father's Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Social Security Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Social Security Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Person financially responsible (if other than parent): _____

Address: _____ City: _____ State: ____ Zip: _____

I hereby authorize payment directly to R. Carson Kight, D.M.D., of the group insurance benefits otherwise payable to me. To my best knowledge, information above is correct and complete. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Dentistry for Children, LLC to release information necessary to secure payment of benefits. I agree to be responsible for all charges for dental services paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim and consent to the use and disclosure of protected health information to carry out treatment, payment and healthcare operations.

Signature: _____ Date: _____

10 Tea Olive Court | Aiken, South Carolina, 29803 | 803.648.7400 | Fax: 803.641.0430 | rcarsonkightdmd@aol.com