TED LOIBEN, D.D.S. PEDIATRIC DENTIST, LTD.

Patient/Parent Information

Mother's Name _____ SS# _____ Birthdate _____

Father's Name _____ SS# _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Cell Phone (Mother) _____ Cell Phone (Father) _____

Home Phone _____ E-Mail _____

Bus. Phone (Mother) _____ Occupation _____

Company Name _____

Bus. Phone (Father) _____ Occupation _____

Company Name _____

Other Parent If At Different Address

Name _____ Cell Phone # _____

Address _____E-Mail _____

City _____ State _____ Zip _____

Patient Full Name(s)	**M/F**	**Birthdate**	**Nickname?**
1) _____	/____/	_____	_____
2) _____	/____/	_____	_____
3) _____	/____/	_____	_____
4) _____	/____/	_____	_____

I understand and acknowledge that I am financially responsible for all charges for professional services rendered to the family member(s) listed above. I am aware that I may be charged a fee for missed appointments or cancellations with less than 48 hours notice.

Signature: _____ Date: _____

I will be paying for today's professional services by: **[ ] Cash [ ] Check [ ] Visa**
[ ] American Express [ ] MasterCard [ ] Discover