Lefkoff
PERIODONTICS
Maureen H. Lefkoff, DDS, MS, PA

# Child Patient Information Form

**Child Information**

| last name | first name | middle name | preferred name | |
|---|---|---|---|---|
| street address | | city | state | zip |
| home phone | social security number | birth date (mm/dd/yyyy) | sex [ ] Male [ ] Female | |
| referred by | | present dentist | | |
| emergency contact | | | phone | |
| physician | | | phone | |
| physician address | | city | state | zip |

**Parent Information**

| last name | first name | middle name | preferred name | |
|---|---|---|---|---|
| street address | | city | state | zip |
| home phone | work phone | cell phone | email | |

**Primary Dental Insurance**

| insured's name | | insured's employer | | |
|---|---|---|---|---|
| insured's birth date | insured's social security number or identification number | | relationship to patient | |
| insurance company | | phone number | group number | |
| insurance company address | | city | state | zip |

**Secondary Dental Insurance**

| insured's name | | insured's employer | | |
|---|---|---|---|---|
| insured's birth date | insured's social security number or identification number | | relationship to patient | |
| insurance company | | phone number | group number | |
| insurance company address | | city | state | zip |

I authorize Dr. Lefkoff to release any information requested by any third party payer regarding charges incurred by this patient. In addition, I authorize the use of the signature on all insurance submissions.

Parent/Guardian Signature

Date