Tricia A. Ray, D.M.D., PC (503) 363-1661
dentistry for children and young adults 140 ramsgate square s., suite 120, salem, or 97302

Parent's Information

☐ Parent ☐ Guardian ☐ ____________

Name____________________ Birthdate____________ Soc. Sec. #____________
Address____
City__________ State_____ Zip__________ Home Phone____________ Cell Phone____________
Mailing Address (if different)________________________________
Employer________________________________ Work Phone____________

☐ Parent ☐ Guardian ☐ ____________

Name____________________ Birthdate____________ Soc. Sec. #____________
Address____
City__________ State_____ Zip__________ Home Phone____________ Cell Phone____________
Mailing Address (if different)________________________________
Employer________________________________ Work Phone____________

Emergent Contact

Name____________________ Relationship to Patient____________________
Address____
City__________ State_____ Zip__________ Home Phone____________ Cell Phone____________

Children

Name____________________ ☐ Male ☐ Female Age_____ Birthdate____________
Name____________________ ☐ Male ☐ Female Age_____ Birthdate____________
Name____________________ ☐ Male ☐ Female Age_____ Birthdate____________
Name____________________ ☐ Male ☐ Female Age_____ Birthdate____________
Name____________________ ☐ Male ☐ Female Age_____ Birthdate____________
Name____________________ ☐ Male ☐ Female Age_____ Birthdate____________

Primary Dental Insurance

Insurance Co. Name________________________ Phone____________
Address____________________ City__________ State_____ Zip__________
Subscriber Name____________________ Birthdate____________ ID #____________
Employer________________________________ Group #____________

Secondary Dental Insurance

Insurance Co. Name________________________ Phone____________
Address____________________ City__________ State_____ Zip__________
Subscriber Name____________________ Birthdate____________ ID #____________
Employer________________________________ Group #____________

Authorization

I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the insurance company(s) indicated on this form to pay the dentist all insurance benefits for services rendered. I authorize Dr. Ray to release all information necessary to secure the payment of benefits.

Signature________________________________ Date____________

Acknowledgement of Receipt of Notice of Privacy Practices

Tricia A. Ray, DMD, PC

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* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:______________________________

Signature:______________________________

Date:______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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PARENT OR LEGAL GUARDIAN CONSENT FOR DENTAL TREATMENT

____

Child's Name **Date of Birth**

____

Parent or Legal Guardian **Phone Number**

<u>Authorized Caregiver's Information</u>

____

Caregiver's Name **Phone Number**

The above named caregiver shall be authorized to consent for all dental treatment, for the above named child, which may be required during my absence. I agree to pay for all services provided to my child that the caregiver authorized.

If circumstances permit and/or if the office of Tricia A. Ray, DMD, PC needs to contact me, please contact me at the following telephone number:______________________________

This consent serves as permission for treatment by Tricia A. Ray, DMD, PC and her associates for the above named child. **<u>This authorization shall be effective until:</u>**

One (1) year from date signed ____________________ Parent or Legal Guardian's Initials

OR

Until __________________________ (list Month, Day, Year)

This authorization will remain in effect until the date stated above- unless I revoke this authorization in writing and submit it to Tricia A. Ray, DMD, PC prior to this date.

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Signature Parent or Legal Guardian **Date**

<u>*Note: Consents are NOT required in emergency situations.</u>**