



# Confidential Financial Information

TODAY'S DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Charles E. Montoure, DDS, MS**  
**Mark H. Hanson, DDS, MS**

## MINOR PATIENT INFORMATION

PATIENT:			SEX: <input type="checkbox"/> M <input type="checkbox"/> F	AGE:	DATE OF BIRTH: / /
PARENT'S MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single			PATIENT LIVES WITH: <input type="checkbox"/> Both <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other		
<p>Montoure &amp; Hanson Orthodontics offers interest-free payment options based on credit worthiness. In order to set up your account at our office, please fill out the following information for each parent in its entirety. Your Social Security Number may be needed to obtain credit history, or for filing a claim with your insurance, and will not be disclosed for any other purpose. Please initial that you have read and understand this information. INITIAL: _____</p>					
<b>MOTHER:</b>			<b>FATHER:</b>		
SOCIAL SECURITY #:	DATE OF BIRTH: / /		SOCIAL SECURITY #:	DATE OF BIRTH: / /	
ADDRESS:			ADDRESS:		
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:
<input type="checkbox"/> Own <input type="checkbox"/> Rent		YEARS AT THIS ADDRESS:	<input type="checkbox"/> Own <input type="checkbox"/> Rent		YEARS AT THIS ADDRESS:
HOME PHONE:	CELL PHONE:		HOME PHONE:	CELL PHONE:	
EMPLOYER:			EMPLOYER:		
POSITION (IF SELF EMPLOYED, LIST FIELD):			POSITION (IF SELF EMPLOYED, LIST FIELD):		
WORK PHONE:	YEARS AT THIS EMPLOYMENT:		WORK PHONE:	YEARS AT THIS EMPLOYMENT:	
EMAIL ADDRESS:			EMAIL ADDRESS:		
SPOUSE (IF APPLICABLE):			SPOUSE (IF APPLICABLE):		
SOCIAL SECURITY #:	DATE OF BIRTH: / /		SOCIAL SECURITY #:	DATE OF BIRTH: / /	
<p>Montoure &amp; Hanson Orthodontics will submit insurance claims on your behalf. Please bring your current dental insurance card(s) with you to your child's exam and fill out the following information in its entirety. We will verify your orthodontic coverage and provide you with an estimate for treatment based on this information.</p>					
Dental Insurance is through (please circle): MOTHER / STEP-MOTHER			Dental Insurance is through (please circle): FATHER / STEP-FATHER		
DENTAL CARRIER:			DENTAL CARRIER:		
<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> No Dental Insurance			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> No Dental Insurance		
MEMBER#:			MEMBER#:		
GROUP#:			GROUP#:		
INSURANCE CO. ADDRESS:			INSURANCE CO. ADDRESS:		
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:
INSURANCE CO. PHONE:			INSURANCE CO. PHONE:		
I hereby authorize payment directly to Montoure & Hanson Orthodontics. _____			I hereby authorize payment directly to Montoure & Hanson Orthodontics. _____		
<i>Signature of Insured Person</i>			<i>Signature of Insured Person</i>		

I certify the information on this form is true to the best of my knowledge. I accept responsibility for the dental charges incurred. I understand my dental insurance provider may pay less than the actual bill for services and I am ultimately responsible for any balances due. I understand that I am responsible for any late fees, missed appointments and/or collection fees incurred. I also understand that where appropriate, credit bureau reports may be obtained. I acknowledge that Montoure & Hanson Orthodontics will provide me with a copy of their Privacy Practices upon request.

Signature of Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_