Darcy Amacher, D.D.S
105 Akers Farm Rd.
Christiansburg, Va 24073
(540) 394-3300

Patient Information-

Child's FULL name________________________ Likes to be called____________
Birthdate____________ Age ________ Sex: M F School____________
Home address (street, city, zip code)________________________
Mailing address(if different)________________________
Home Telephone # ____________ Child lives with________________
Names and ages of brothers and/or sisters________________________
****

Parent Information-

Father / Legal Guardian________________________ Marital Status____________
Address (if different)________________ H#____________ Cell#____________
Employer________________ Work #____________ Pager #____________
Birthdate____________ Social Security #____________ E-mail ____________

Mother / Legal Guardian________________________ Marital Status____________
Address (if different)________________ H#____________ Cell #____________
Employer________________ Work #____________ Pager#____________
Birthdate____________ Social Security #____________ E-mail____________
How did you hear about our practice?________________________
****

Dental Insurance Information-

Name of Primary Dental Insurance: ____________ Group #____________ Eff date____________
Subscriber's Name________________ ID# ____________ Birthdate____________
Ins company address________________________ Phone #____________

Name of Secondary Dental Insurance:____________ Group#____________ Eff date____________
Subscriber's Name________________ ID #____________ Birthdate____________

Medical Insurance Information-

Name of Insurance Company________________ Group #____________
Subscriber's Name________________ SSN#____________ Birthdate____________
Ins company address________________________ Phone #____________
****

Whom may we contact in case of emergency? **(Other than parents)**
Name________________ Phone # ____________ Relationship____________

Name of another person (friend or family member) not living with you________________
Phone#____________ Cell #____________ Relationship____________

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor, of insurance benefits under which I am entitled.

Signed:________________________________ Date:____________