

WELCOME

≈SECTION ONE – TELL US ABOUT YOUR CHILD≈

Today's Date: _____ SS#: _____

CHILD'S NAME: _____
Last First Middle Name

Nickname: _____ Birthdate: ____/____/____ Age: _____ Male Female

Home Address: _____

School: _____ Grade: _____ City State Zip Code

≈SECTION TWO – WHO IS ACCOMPANYING THE CHILD TODAY?≈

Name: _____ Relation: _____

Do you have legal custody of this child? YES NO Is this child adopted? YES NO Is child in a foster home? YES NO

Whom may we Thank for referring you? _____ Other family members seen by us: _____

Previous/Present Dentist: _____ Phone #: _____ Last Visit Date: _____

≈SECTION THREE – PARENT'S INFORMATION≈

MOTHER: Step Mother Guardian Birthdate: ____/____/____ SS #: _____

Name: _____ Home #: (____) _____ Cell #: (____) _____

Employer: _____ Work #: (____) _____

FATHER: Step Father Guardian Birthdate: ____/____/____ SS #: _____

Name: _____ Home #: (____) _____ Cell #: (____) _____

Employer: _____ Work #: (____) _____

≈SECTION FOUR – PERSON RESPONSIBLE FOR ACCOUNT≈

NAME: _____ Relation: _____

Billing Address: _____ SS #: _____

Home #: (____) _____ Work #: (____) _____ Employer: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name: _____ Home #: (____) _____ Cell #: (____) _____

≈SECTION FIVE - INSURANCE≈

PRIMARY INSURANCE Dental Coverage YES NO Orthodontic Coverage YES NO

Insurance Co. Name: _____ Phone: _____

Insurance Co. Address: _____

Insured's Name: _____ Relationship to Patient: _____

Group # (Plan, Local, Policy): _____ Insured's ID#: _____

Insured's Birthdate: ____/____/____ Insured's SS#: _____

Insured's Employer: _____ Address: _____

SECONDARY INSURANCE Dental Coverage YES NO Orthodontic Coverage YES NO

Insurance Co. Name: _____ Phone: _____

Insurance Co. Address: _____

Insured's Name: _____ Relationship to Patient: _____

Group # (Plan, Local, Policy): _____ Insured's ID#: _____

Insured's Birthdate: ____/____/____ Insured's SS#: _____

Insured's Employer: _____ Address: _____

