

WELCOME!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ Male Female

Child's Birthdate: ____ / ____ / ____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____

APT / CONDO #

CITY

STATE

ZIP

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

Wk #: (____) _____ Ext: ____ Hm #: (____)

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext: ____ Hm #: (____)

2 Who Is Accompanying The Child Today?

Name: _____

Relation: _____

Do you have legal custody of this child? Yes No

Whom may we **Thank** for referring you: _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last visit date: _____

Parent's Marital Status: Single Married Widowed Divorced Separated

3 Mother's Information Step Mother Guardian

Email address: _____

Name: _____ Birthdate: ____ / ____ / ____

Wk #: (____) _____ Ext: ____ Hm #: (____)

Employer: _____

SS #: _____ DL #: _____

Father's Information Step Father Guardian

Name: _____ Birthdate: ____ / ____ / ____

Wk #: (____) _____ Ext: ____ Hm #: (____)

Employer: _____

SS #: _____ DL #: _____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Birthdate: ____ / ____ / ____ SS #: _____

Policy Owner's Employer: _____

Orthodontic coverage? Yes No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Birthdate: ____ / ____ / ____ SS #: _____

Policy Owner's Employer: _____

Orthodontic coverage? Yes No

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