

# 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

## 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: \_\_\_/\_\_\_/\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Orthodontic coverage?  Yes  No

## 3 Mother's Information Step Mother Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

SS #: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

## Father's Information Step Father Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

SS #: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

## 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: \_\_\_/\_\_\_/\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Orthodontic coverage?  Yes  No

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