Welcome To Our Practice!

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime

Tell Us About Your Child

Today's Date:____________

Child's Name: (LAST, FIRST, MI) ____________________ Nickname:____________

Birthdate: ____/____/____ Age: ______ ☐ Male ☐ Female School: ____________ Grade:______

Hobbies / Sports: ____________________

Child's Home #:____________ **Child's Home Address:** ____________________

APT/CONDO #

____

CITY STATE ZIP

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? ____________________

List brothers / sisters with age: ____________________

General Dentist: ____________________ Last Visit Date:____________

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Mother's Information

☐ Step Mother ☐ Guardian

Name: ____________ Birthdate:____/____/____

Wk #:____________ Ext.______ Hm #: ____________

Cell #: ____________________

Employer: ____________________

How long at current job:__________ Job title: __________

SS #: ____________ E-Mail: ____________

Father's Information

☐ Step Father ☐ Guardian

Name: ____________ Birthdate:____/____/____

Wk #:____________ Ext.______ Hm #: ____________

Cell #: ____________________

Employer: ____________________

How long at current job:__________ Job title: __________

SS #: ____________ E-Mail: ____________

Person Responsible for Account

Name:____________________ Relation:____________

Billing Address: (CITY, STATE, ZIP) ____________________

Previous Address: (CITY, STATE, ZIP) ____________________

Hm #:____________ Cell #:____________ Employer: ____________

Wk #:____________ Ext.______ SS #:____________

E-Mail: ____________________

Primary Dental Insurance

Orthodontic Coverage? ☐ Yes ☐ No

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:____________ Employer's Address:____________

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

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:____________ Employer's Address:____________

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