FOR CHILDREN: WELCOME TO OUR PRACTICE

1.) TELL US ABOUT YOUR CHILD

Today's date: ____________ DOB: ____________

Child's Name: AGE: ____________

Last First Mi

Nickname: ____________ Male | Female

School: ____________ Grade: ____________

Home #: ____________

SS #: ____________

Child's Home Address:

Apt#

City State Zip

Siblings:

Name ____________ Age ______

Name ____________ Age ______

2.) WHO IS WITH THE CHILD TODAY?

Name: ____________

Relation: ____________

Do you have legal custody of this child?

YES NO

Who may we thank for referring you? ____________

Other family members seen by us:

Previous/Present Dentist: ____________

Street: ____________

Phone #: ____________ Last Visit: ____________

Parent's Marital Status: ____________
(single, married, divorced)

3.) MOTHER'S INFORMATION:

Name: ____________

WK#: ____________ Ext. ______ HM#: ____________

Employer: ____________

DL#: ____________

SS#: ____________

FATHER'S INFORMATION:

Name: ____________

WK#: ____________ Ext. ______ HM#: ____________

Employer: ____________

DL#: ____________

SS#: ____________

4.) RESPONSIBLE PARTY INFO:

Name: ____________

Billing address: ____________

City State Zip

WK#: ____________ Ext. ______ HM#: ____________

Cell #: ____________

Email: ____________

Employer: ____________

DL#: ____________

SS#: ____________

Who is responsible for making appts?

Name: ____________

WK#: ____________ Ext. ______ HM#: ____________

5.) PRIMARY DENTAL INSURANCE:

Ins. Name: ____________

Ins. Address: ____________

Insurance Co. Phone #: ____________

Group/Policy # ____________

Insured's Name: ____________

Relationship to Patient: ____________

Insured's DOB: ____________

Insured's Employer: ____________

SS#: ____________

Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: ____________

Ins. Address: ____________

Insurance Co. Phone #: ____________

Group/Policy # ____________

Insured's Name: ____________

Relationship to Patient: ____________

Insured's DOB: ____________

Insured's Employer: ____________

SS#: ____________

Orthodontic Coverage: YES NO

OR 1C (200)
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