

FOR CHILDREN: WELCOME TO OUR PRACTICE

1) TELL US ABOUT YOUR CHILD

Today's date: _____ DOB _____

Age: _____

Child's Name:

Last

First

Mi

Nickname: _____ Male Female

School: _____ Grade: _____

Home #: _____

Child's Home Address:

_____ Apt # _____

_____ City State Zip

4) RESPONSIBLE PARTY INFO:

Name: _____

Billing Address: _____

City

State

Zip

WK#: _____ Ext _____ HM# _____

Employer: _____

DL#: _____

SS#: _____

Who is Responsible for Making Appointments?

Name: _____

WK#: _____ Ext _____ HM# _____

2) WHO IS WITH THE CHILD TODAY?

Name: _____

Relationship: _____

Do you have legal custody of this child? Yes No

Who may we thank for referring you?: _____

Other family members seen by us: _____

Name of Sibling: _____ Age: _____

Name of Sibling: _____ Age: _____

Previous / Present Dentist: _____

_____ Last Visit: _____

Parent's Marital Status: _____

(single, married, divorced)

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

3) MOTHER'S INFORMATION:

Name: _____

WK#: _____ Ext _____ HM# _____

Employer: _____

DL#: _____

SS#: _____

FATHER'S INFORMATION:

Name: _____

WK#: _____ Ext _____ HM# _____

Employer: _____

DL#: _____

SS#: _____

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

