

FOR CHILDREN: WELCOME TO OUR PRACTICE

1. TELL US ABOUT YOUR CHILD

Today's date: _____ DOB: _____

Child's Name: _____ Age: _____

Last _____ First _____ Middle _____

Preferred Name: _____ Male Female

School: _____ Grade: _____

Home#: _____ Cell#: _____

Email: _____ SS#: _____

Hobbies / Special Interests: _____

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: _____ Cell#: _____

WK#: _____ Home#: _____

Employer: _____

SS#: _____

4. FATHER'S INFORMATION

Name: _____ Cell#: _____

WK#: _____ Home#: _____

Employer: _____

SS#: _____

5. RESPONSIBLE PARTY INFO

Name: _____

Billing address : _____

City _____ State _____ Zip _____

WK#: _____ Home#: _____

Cell#: _____

Email: _____

Employer: _____

SS#: _____

6. 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

7. 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

