WELCOME

We would like to welcome you and your child to our practice. 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

CHILD'S NAME_____ / _____ / _____
Last First MI

Child's Birthdate: ___/ ___/ ___ Child's Age:_____ Nickname:_____ Male __ Female__

Home Phone:_____ Cell Phone:_____ Child's SS#_____

Home Address:_____
Apt/Condo# City State Zip

Whom may we thank for referring him or her? _____

Siblings _____

Previous/Present Dentist:_____

PARENT'S INFORMATION Please Circle

Parent's marital status: Single Married Widowed Divorced Separated Domestic-Partnership

Mother Father Step-Parent Guardian

Name_____

Address:_____

_____

Birthdate:____/____/____ SS#_____

Work phone:_____

Cell phone:_____

Employer_____

Email:_____

Driver's License #_____

Mother Father Step-Parent Guardian

Name_____

Address:_____

_____

Birthdate:____/____/____ SS#_____

Work phone:_____

Cell phone:_____

Employer_____

Email:_____

Driver's License #_____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name:_____Relationship:_____

Do you have legal custody of the child? Yes___ No___ Is the child adopted? Yes___ No___ Is the child in a foster home? Yes___ No___

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____Relationship:_____

Billing Address:_____
City State Zip

PRIMARY INSURANCE

Dental Insurance:_____

Address:_____

_____
City State Zip

Policy Holder:_____

Birthdate: ___/___/___ SS#_____

Member ID# _____

Group #:_____

Secondary Insurance: Y____N____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform the office of any changes. I understand that I am responsible for the payment of services rendered and also responsible for paying any deductible or copayment that my insurance does not cover.

Signature:_____ Date:_____