Welcome

Thank you for selecting our dental healthcare team to serve your dental needs. We shall endeaveor to provide you with quality dental healthcare. Our office is committed to meeting or exceeding the standards of infection control. Please fill out this form completely. If you have any questions now or at any time during your treatment, please do not hesitate to ask. The better we communicate, the better we can care for you.

1. Tell Us About Your Child

Today's Date: _____

Child's Name: _____ (LAST / FIRST / MI)

Nickname: _____ ❑ Male ❑ Female

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: _____ SS# _____

Child's Home Address:

_____ (APT / CONDO #)

_____ (CITY / STATE / ZIP)

2. 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? _____

_____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced ❑ Separated

3.

Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____ Birthdate ___/___/___

Wk #: _____ Ext: _____ Hm#: _____

Employer: _____

SS #: _____ DL#: _____

Father's Information: ❑ Step Father ❑ Guardian

Name: _____ Birthdate ___/___/___

Wk #: _____ Ext: _____ Hm#: _____

Employer: _____

SS #: _____ DL#: _____

4. Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____ (CITY / STATE / ZIP)

Wk #: _____ Ext: _____ Hm#: _____

Employer: _____

SS #: _____ DL#: _____

Who is Responsible for Making Appointments?

Name: _____

Wk #: _____ Ext: _____ Hm#: _____

5. Primary Dental Insurance

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: _____

Orthodontic Coverage? ❑ Yes ❑ No

Secondary Dental Insurance

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: _____

Orthodontic Coverage? ❑ Yes ❑ No