The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

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 ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

3 ❑ Mother's Information ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ___/___/___

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Work #: (____)_____

Email: _____ SS #: _____

❑ Father's Information ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ___/___/___

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Work #: (____)_____

Email: _____ SS #: _____

4 Person Responsible For Account

Name: _____ **Relation:** _____

Billing Address: _____

_____

Wk #: (____)_____ **Ext:** ____ **Hm #:** (____)_____

DL #: _____ SS #: _____

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: ___/___/___ ID #: _____

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: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Orthodontic coverage? ❑ Yes ❑ No

CONTINUED ON BACK