



Welcome

PATIENT INFORMATION (CHILD)

Thank you for entrusting your child to our care. Our goal is to provide pleasant experiences as your child develops healthy teeth and an attractive smile. The information on these forms will allow us to provide the best care possible.

First Name _____ MI ____ Last Name _____ Today's Date ___/___/___

I like to be called _____ Birthdate ___/___/___

Home address _____ City _____ Zip _____

Home Phone _____ Cell/Pager _____

Adults living at home with you:

Name _____ Relationship _____

Name _____ Relationship _____

If you are a student, name of school/college _____ Yr. in school _____

How did you hear about our practice? _____

Other than your home, an adult to contact in case of emergency: Name _____

Relation to patient _____ Home Ph # _____ Cell Ph # _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relation to patient _____ Home Ph # _____ Cell Ph # _____

Billing address _____ City _____ Zip _____

Occupation _____ Employer _____

Business address _____ Work Ph # _____

FOR OUR PATIENTS WITH DENTAL INSURANCE ...

Name of policyholder _____ Birthdate ___/___/___ SS# _____

Insurance Co. _____ Group #. _____

Name of employer _____ Relation to patient _____

Are you covered by another insurance plan?

Name of policyholder _____ Birthdate ___/___/___ SS# _____

Insurance Co. _____ Group #. _____

Name of employer _____ Relation to patient _____