

FOR CHILDREN: WELCOME TO OUR PRACTICE

1.) TELL US ABOUT YOUR CHILD

Today's date: _____ DOB: _____
 Child's Name: _____ AGE: _____

Last _____ First _____ MI _____
 Preferred Name: _____ M / F _____
 School: _____ Grade: _____
 Home#: _____
 Who does the child live with?: _____
 Child's Home Address: _____
 _____ Apt# _____
 City _____ State _____ Zip _____
 Child's Mailing Address (if different from home address): _____
 _____ Apt# _____
 City _____ State _____ Zip _____

2.) WHO IS WITH YOUR CHILD TODAY?

Name: _____
 Are You: Mother / Father / Stepparent / Other _____
 Birth Parent's Martial Status (Please Circle):
 Married / Divorced / Separated _____
 Who has legal custody of this child?

 Who may we thank for referring you? _____

 Other family members seen by us: _____

 Child's Current Dentist: _____
 City: _____
 Phone: _____ Last Visit: _____

3.) MOTHER INFORMATION:

Name: _____
 Address: _____
 Phone#: _____
 Work#: _____ Ext. _____
 Employer: _____
 SS#: _____ DOB: _____

4.) FATHER INFORMATION:

Name: _____
 Address: _____
 Phone#: _____
 Work#: _____ Ext. _____
 Employer: _____
 SS#: _____ DOB: _____

4.) RESPONSIBLE PARTY INFO:

Name: _____
 Mailing address: _____

 City _____ State _____ Zip _____
 HM#: _____ Cell#: _____
 WK#: _____ Ext. _____
 Email: _____

Emergency Contact:

Name: _____ Relation: _____
 Wk#: _____ Ext. _____ HM# _____

5.) PRIMARY DENTAL INSURANCE:

Ins. Name: _____
 Ins. Address: _____

 Insurance Phone #: _____
 Group/Policy #: _____
 ID#: _____
 Insured's Name: _____
 Relationship to Patient: _____
 Insured's DOB: _____
 Insured's Employer: _____
 SS#: _____
 Do you have orthodontic coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: _____
 Ins. Address: _____

 Insurance Phone #: _____
 Group/Policy #: _____
 ID#: _____
 Insured's Name: _____
 Relationship to Patient: _____
 Insured's DOB: _____
 Insured's Employer: _____
 SS#: _____
 Orthodontic Coverage: YES NO

