

Patient ID# _____
Today's Date _____

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
SS#/SIN _____
School _____ Grade _____
Child's Home Address _____
City _____
State/Prov. _____ Zip/P.C. _____
Phone _____

Responsible Party

Name _____
Relationship _____
Address _____
SS#/SIN _____
DL# _____
Email _____
Phone _____

Mother

Stepmother Guardian

Name _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS#/SIN _____
Employer _____
Occupation _____
DL# _____

Father

Stepfather Guardian

Name _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS#/SIN _____
Employer _____
Occupation _____
DL# _____

Primary Dental Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Emp. _____
Occupation _____

Ins. Company _____ Group # _____ Emp. # _____

Ins. Company Address _____

Deductible _____ Amount already used _____ Max. annual benefit _____

Orthodontic coverage Yes No

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____ Employer _____

Date Emp. _____ Occupation _____

Ins. Company _____ Group # _____ Emp. # _____

Ins. Company Address _____

Deductible _____ Amount already used _____

Max. annual benefit _____

Orthodontic coverage

Yes No

Parent's Marital Status

Single Divorced

Married Widowed

Separated

Who is responsible for making appointments?

Name _____

Home Phone _____

Work Phone _____ Ext. _____

Cell Phone _____

Best time to call (Time) _____ (Days) _____

Over Please