



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is

based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

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
 Email Address: _____

4 Person Responsible For Account
 Name: _____ Relation: _____
 Billing Address: _____
CITY STATE ZIP
 Wk #: (____) _____ Ext: ____ Hm #: (____) _____
 Employer: _____
 DL #: _____ SS #: _____
Who is responsible for making appointments?
 Name: _____
 Wk #: (____) _____ Ext: ____ Hm #: (____) _____

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: _____
(Please Circle)
 Last Visit Date: _____
 Parent's Marital Status: Single Widowed Partnered
 Married Divorced Separated

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

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 #: _____

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

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