CHILD'S NAME: _____ **DATE:** _____
first middle last

Nickname: _____ ❒Male ❒Female

Child's Birthdate:_____/_____/_____ Age: _____

Child's Home #: _____

Child's Home Address: _____

_____
City State Zip Code

WHO IS ACCOMPANYING CHILD TODAY?

Name:_____ Relationship:_____

Do you have legal custody of this child? ❒Y ❒N

Who may we thank for reffering you?_____

Other family members seen by us: _____

_____

Child's previous dentist: _____

Last visit date: _____

MOTHER'S INFORMATION (❒Stepmother ❒Guardian)

Name: _____

Address (if different): _____

_____
City State Zip Code

Work # _____ Ext:_____ Home #: _____

Employer:_____

Social Security #:_____

FATHER'S INFORMATION (❒Stepfather ❒Guardian)

Name: _____

Address (if different): _____

_____

_____
City State Zip Code

Work # _____ Ext:_____ Home #: _____

Employer:_____

Social Security #:_____

EMERGENCY CONTACT
(nearest relative/friend at different address)

Name/Relationship: _____

Address: _____

_____
City State Zip Code

Phone #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name/Relationship: _____

Billing Address: _____

_____
City State Zip Code

Work # _____ Ext:_____ Home #: _____

Employer:_____

Social Security #:_____

PRIMARY DENTAL INSURANCE

Insurance Company: _____

Claims Address: _____

_____

Phone #: _____

Group or Policy #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate:_____/_____/_____ SS#: _____

Insured's Employer:_____

SECONDARY INSURANCE

Insurance Company: _____

Claims Address: _____

_____

Phone #: _____

Group or Policy #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate:_____/_____/_____ SS#: _____

Insured's Employer:_____

RESPONSIBILITY FOR FEES

I understand that I am responsible for payment of all fees for dental services provided on behalf of my child and such payment is due in full at the time of service unless prior arrangements have been made. I understand that submission of dental claims to my insurance company is a courtesy and I am responsible for fees not covered by insurance.

_____
Signature of Parent/Guardian