

WELCOME

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.



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 #: _____

E-mail Address: _____

Child's Home Address: _____
CITY STATE ZIP APT/CONDO #



Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____
CITY STATE ZIP

Hm #: (____) _____ DL #: _____

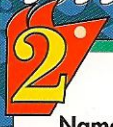
Employer: _____

Wk #: (____) _____ Ext: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____



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: _____

Last Visit Date: _____

Parent's Marital Status: Single Widowed Married Divorced Separated



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: _____

Employer's Address: _____

Orthodontic Coverage? Yes No



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: _____

Employer's Address: _____

Orthodontic Coverage? Yes No