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