



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

**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 #: \_\_\_\_\_

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Orthodontic Coverage?  Yes  No

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Orthodontic Coverage?  Yes  No

