

WELCOME!

We would like to welcome 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

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

Nickname: _____ Male Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo # _____

City State Zip

General Information

Who is accompanying the child today?
Name: _____ Relation: _____
 Yes No

Do you have legal custody of this child? Yes No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous/Present Dentist: _____ Last Visit Date: _____

Dentist's Phone: (____) _____

Relative or Friend not living with you:
Name: _____ Phone: (____) _____

Address: _____
City State Zip

Parent's Information

Who is responsible for account? _____ Parent's Marital Status
 Single Married Partnered Widowed Divorced Separated

Father Step Father Guardian
Name: _____ Birthdate: ____/____/____
Address: (If different than Child's) Hm #: (____) _____
SS #: _____ DL #: _____
Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____
Email: _____
Employer: _____
Employer's Address: _____
City State Zip

Mother Step Mother Guardian
Name: _____ Birthdate: ____/____/____
Address: (If different than Child's) Hm #: (____) _____
SS #: _____ DL #: _____
Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____
Email: _____
Employer: _____
Employer's Address: _____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:
Insurance Co. Name: _____
Insurance Address: _____
City State Zip
Insurance Phone: (____) _____
Group # (Plan, Local, or Policy #): _____

If you have Dental Insurance Coverage for the Child, please fill out below:
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Insurance Address: _____
City State Zip
Insurance Phone: (____) _____
Group # (Plan, Local, or Policy #): _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

CONTINUED ON BACK

