

CHILD PATIENT INFORMATION

Patient Name _____ Preferred Name _____
Last First Middle

Address _____ Sex M F

City _____ State _____ Zip _____ Home (____) _____

Birthdate _____ Age _____ School _____ Grade _____

Whom may we thank for referring you to our office? _____

PARENT(S) OR GUARDIAN INFORMATION

Name _____	Name _____
Address _____	Address _____
Soc. Sec. # _____	Soc. Sec. # _____
Employer _____	Employer _____
Home Phone# (____) _____	Home Phone# (____) _____
Cell Phone# (____) _____	Cell Phone# (____) _____
Work Phone# (____) _____	Work Phone# (____) _____
Email Address _____	Email Address _____

I would like to receive correspondence via E-mail Text Messaging

PRIMARY DENTAL INSURANCE

Subscriber Name _____	Employer Name _____
ID # _____ Group # _____	Relationship to Patient _____
Subscriber SS# _____	Subscriber Birthdate _____
Insurance Company _____	Insurance Co. Phone# _____
Insurance Company Address _____	

SECONDARY DENTAL INSURANCE

Subscriber Name _____	Employer Name _____
ID # _____ Group # _____	Relationship to Patient _____
Subscriber SS# _____	Subscriber Birthdate _____
Insurance Company _____	Insurance Co. Phone# _____
Insurance Company Address _____	

EMERGENCY CONTACT

Nearest relative or friend, not living with you, whom we may contact in an emergency:

Name _____	Relationship _____
Address _____	Home # _____
City _____ State _____ Zip _____	Cell # _____
	Work # _____

 Parent or Guardian Signature Date