Welcome

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: (____)_____ Social Security #: _____

Child's Name: _____ (Last / First / MI) Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ❑ Male ❑ Female School: _____ Grade: _____

Child's Home Address: _____ (Street / City / State / Zip)

Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No Is the child adopted? ❑ Yes ❑ No Is the child in a foster home? ❑ Yes ❑ No

Whom may we Thank for referring you? _____ Other siblings seen by us: _____

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____ (Street / City / State / Zip)

Parent's Information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single

Mother: ❑ Step Mother ❑ Guardian Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____)_____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____ (Street / City / State / Zip)

Employer: _____ Length of Employment: _____

Father: ❑ Step Father ❑ Guardian Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____)_____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____ (Street / City / State / Zip)

Employer: _____ Length of Employment: _____

Person Responsible for Account

Name: _____ Relationship: _____ Social Security #: _____

Billing Address: _____ (Street / City / State / Zip)

Work Phone #: (____)_____ Home Phone #: (____)_____ Employer: _____ Driver's License #: _____

Who is responsible for making appointments?

Name: _____ Work Phone #: (____)_____ Home Phone #: (____)_____ Best time to call: _____

Insurance Information

Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____ (PO Box/Street / City / State / Zip)

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____

Employer's Address: _____ (Street / City / State / Zip)

Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____ (PO Box/Street / City / State / Zip)

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____

Employer's Address: _____ (Street / City / State / Zip)

CONTINUED ON BACK