

WELCOME

Tell Us About

Today's Date: ___/___/___ Nickname: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/___ Age: _____ Male Female

E-mail Address: _____

School: _____ Grade: _____

Hobbies/Sports: _____

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

Child's Home Address: _____
Apt / Condo #

City State Zip

General

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 siblings: _____

General Dentist: _____ Last Visit Date _____

Dentist's Phone #: (____) _____

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

Address: _____
City State Zip

Parent

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)

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Email: _____ Cell #: (____) _____

Employer: _____ Occupation: _____

Employer's Address:

City State Zip

Mother Step Mother Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's)

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Email: _____ Cell #: (____) _____

Employer: _____ Occupation: _____

Employer's Address:

City State Zip

If you have Orthodontic 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 Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date