Welcome!

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!

TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____
Last First M.I.

Child's Birthdate: _____ Child's Age: _____

Nickname: _____ ( ) Male ( ) Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: _____ SS #: _____

Child's Home Address: _____
Apt #

_____
City State Zip

GENERAL INFORMATION

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: _____

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) Home #: _____

_____

_____

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) Home #: _____

_____

_____

SS #: _____ DL #: _____

Wk #: _____ Ext: ____ Cell/Other #: _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

PRIMARY INSURANCE

Subscriber's Name: _____

Patient's Relationship to Subscriber: ( ) Self ( ) Spouse ( ) Child

Subscriber ID#: _____ Subscriber's DOB: _____

Insurance Co.: _____ Phone: _____

Insurance Co. Address: _____
Street

_____
City State Zip

Employer: _____

Group Name: _____ Group #: _____

SECONDARY INSURANCE

Subscriber's Name: _____

Patient's Relationship to Subscriber: ( ) Self ( ) Spouse ( ) Child

Subscriber ID#: _____ Subscriber's DOB: _____

Insurance Co.: _____ Phone: _____

Insurance Co. Address: _____
Street

_____
City State Zip

Employer: _____

Group Name: _____ Group #: _____

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:**