



TELL US ABOUT YOUR CHILD:

Today's Date: _____

Child's Name: _____ (male/female)
Last First Mi

Nickname: _____ DOB: _____

Home Tel #: _____ Email: _____

Child's Home Address: _____
Street

Town State Zip

WHO IS WITH THE CHILD TODAY?:

Name: _____ Relation: _____

Who may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Street Town Zip

Tel #: _____ Last Visit: _____

Parent's Marital Status: single married divorced

MOTHER'S INFORMATION:

Name: _____ Tel#: _____

Cell #: _____ Employer: _____ Work tel #: _____

FATHER'S INFORMATION:

Name: _____ Tel#: _____

Cell #: _____ Employer: _____ Work tel #: _____

RESPONSIBLE PARTY INFORMATION:

Name: _____ Tel#: _____

Billing Address: _____
Street Town Zip

Cell #: _____ Employer: _____ Work tel #: _____

PRIMARY DENTAL INSURANCE:

Orthodontic Coverage: YES NO Insurance Co.: _____

Ins. Address: _____
Street Town Zip

Ins. Co. Tel #: _____ Group/Policy #: _____

Insured's Name: _____ Subscriber ID# or SS#: _____

Relation to Patient: _____ Insured's DOB: _____

Secondary Insurance: _____

