

Patient ID# _____

Today's Date _____

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
SS#/SIN _____
School _____ Grade _____
Child's Home Address _____
City _____
State/Prov. _____ Zip/P.C. _____
Phone _____

Responsible Party

Name _____
Relationship _____
Address _____
SS#/SIN _____
DL # _____
Email _____

Mother

Stepmother Guardian

Name _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS#/SIN _____
Employer _____
Occupation _____
DL # _____

Primary Dental Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Emp. _____
Occupation _____

Father

Stepfather Guardian

Name _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS#/SIN _____
Employer _____
Occupation _____
DL # _____

Ins. Company _____ Group # _____ Emp. # _____
Ins. Company Address _____
Deductible _____ Amount already used _____ Max. annual benefit _____
Orthodontic coverage Yes No

Additional Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS#/SIN _____ Employer _____
Date Emp. _____ Occupation _____
Ins. Company _____ Group # _____ Emp. # _____
Ins. Company Address _____
Deductible _____ Amount already used _____
Max. annual benefit _____

Parent's Marital Status

Single Divorced
 Married Widowed
 Separated

Who is responsible for making appointments?

Orthodontic coverage Yes No
Name _____
Home Phone _____
Work Phone _____ Ext. _____
Cell Phone _____
Best time to call (Time) _____ (Days) _____
Over Please