

Please complete the following
confidential information

Date _____ Male
 Female

Child's Name _____

Address _____

City, State, ZIP _____

Home Phone # () _____

Birthdate ____ / ____ / ____ Age _____ Grade _____

School _____

Parents/Guardians _____

If your child's name and address are not the same as yours,
complete the following information also.

Address _____

Home Phone # () _____

Marital Status _____

Getting to Know You

e-mail address _____

Is a relative a patient at our office?Yes No

Referred to us by _____

What is your child's...

 favorite TV show _____

 favorite hobby _____

 favorite person _____

Describe your child's temperament:

 shy aggressive

 outgoing happy

 other _____

Unfavorable medical or dental experience?.....Yes No

(please explain) _____



See Other Side!

Account/Insurance Information

Please complete for each parent/guardian

Person responsible for account: 1 2
Primary Dental Insurance: 1 2

1 Name _____

Relationship to child _____

Employer _____

Occupation _____

Business Address _____

City, State & ZIP _____

Business Phone # () _____

Social Security # ____ / ____ / ____

Birthdate ____ / ____ / ____

Dental Insurance _____

Group # _____

Driver's License # _____

2 Name _____

Relationship to child _____

Employer _____

Occupation _____

Business Address _____

City, State & ZIP _____

Business Phone # () _____

Social Security # ____ / ____ / ____

Birthdate ____ / ____ / ____

Dental Insurance _____

Group # _____

Driver's License # _____