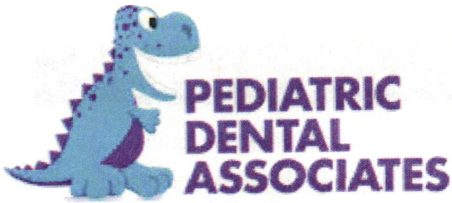

Welcome! to the Pediatric Dentist

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 last a lifetime.

1 Tell us about your child

Today's Date ______

Child's Name ______ LAST ______ FIRST ______ M. INITIAL

Child's Birthdate ______ Child's Age ______

Nickname ______ ☐ Male ☐ Female

School ______ Grade ______

Hobbies/Sports ______

Child's Home # ______ SS# ______

Child's Home Address ______

______ CITY ______ STATE ______ ZIP

2 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? ______

List brothers /sisters with age ______

______

General Dentist ______

Last Exam Date ______ Any Cavities? ______

Parent's Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

3 Parent's Information

Mother ☐ Step Mother ☐ Guardian

Name ______ Birthdate ______

Check which number is best to contact you.

☐ Home ______ ☐ Work ______ ☐ Cell ______

Employer ______

How long at your current job? ____ Job Title? ______

SS# ______ DL# ______

Email

Father ☐ Step Father ☐ Guardian

Name ______ Birthdate ______

Check which number is best to contact you.

☐ Home ______ ☐ Work ______ ☐ Cell ______

Employer ______

How long at your current job? ____ Job Title? ______

SS# ______ DL# ______

Email

4 Person Responsible for account

Name ______ Relation ______

Billing Address ______

______ CITY ______ STATE ______ ZIP

Previous Address ______

Hm# ( ) ______ DL# ______

Employer ______

Wk# ( ) ______ Ext. ______ SS# ______

Who is responsible for making appointments?

Name ______ Birthdate ______

Wk# ( ) ______ Ext. ______ Hm# ______

Neighbor of relative not living with you

Name ______ Phone ______

Address ______

______ CITY ______ STATE ______ ZIP

5 Primary Dental Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name ______

Insurance Co. Address ______

Insurance Co. Phone # ______

Group# (Plan, local,or Policy#) ______

Policy Owner's Name ______

Relationship to Patient ______

Policy Owner's Birthdate ______ S.S# ______

Policy Owners Employer ______

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name ______

Insurance Co. Address ______

Insurance Co. Phone# ______

Group# (Plan, local,or Policy#) ______

Policy Owner's Name ______

Relationship to Patient ______

Policy Owner's Birthdate ______ S.S# ______

Policy Owners Employer ______

All accounts sent to collections will be charged the account balance plus an additional 50%, based on the account balance.