Patient and Family Information:

Child's Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: Mom: _____ Dad: _____

Mother's Name: _____DOB: _____Employer: _____

Work Phone: _____S.S. #: _____ (only for insurance and billing purposes)

Father's Name: _____ DOB: _____Employer: _____

Work Phone: _____ S.S. #: _____ (only for insurance and billing purposes)

Parent's Address (if different from above): _____

Who has legal custody of the child: ____Mother ____Father ____Joint ____Other

Is the child adopted? _____Yes (Date/Location of adoption_____) _____No

Name and ages of siblings: _____

Whom may we thank for referring? _____

Whom may we contact in case of an emergency?

Name: _____ Relationship: _____ Phone: _____

Insurance Information:

Dental Insurance Company: _____ Policy #: _____

Policy Holder: Name: _____ S.S. #: _____

Policy Holder: Address (if different than above): _____

_____Phone: _____

Policy Holder's Employer: _____

Employer's Address: _____

Employer's Phone Number: _____

Medical Insurance Company: _____ Policy #: _____

Policy Holder: Name: _____ S.S. #: _____

Policy Holder: Address (if different than above): _____

_____ Phone: _____

Secondary Insurance: _____ Policy #: _____

Policy Holder: Name: _____ S.S. #: _____

Policy Holder Address (If different than above): _____