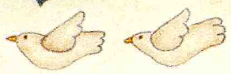
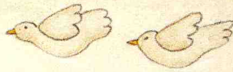
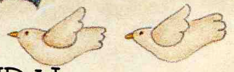

Patient ID No. ____________
Today's Date ____________

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 ____________
E-mail ____________
Birthdate ____________ Age ____________
Social Security No. ____________
School ____________ Grade ____________
Child's Home Address ____________
City ____________
State/Province ____________ Zip/Postal Code ____________
Phone ____________

Mother ☐ Stepmother ☐ Guardian

Name ____________
E-mail ____________
Home Phone ____________
Work Phone ____________
Social Security No. ____________
Employer ____________
Occupation ____________

Father ☐ Stepfather ☐ Guardian

Name ____________
E-mail ____________
Home Phone ____________
Work Phone ____________
Social Security No. ____________
Employer ____________
Occupation ____________

Parents' Marital Status

☐ Single ☐ Married
☐ Divorced ☐ Widowed ☐ Separated

Who is responsible for making appointments?

Name ____________
E-mail ____________
Home Phone ____________
Work Phone ____________
Best time to call (time) ____________ (days) ____________

Responsible Party

Name ____________
E-mail ____________
Relationship ____________
Address ____________
Social Security No. ____________

Primary Dental Insurance

Insured's Name ____________
Relationship ____________
Birthdate ____________ Soc. Sec. No. ____________
Employer ____________ Date Employed ____________
Occupation ____________
Insurance Company ____________
Group No. ____________ Emp. No. ____________
Ins. Company Address ____________
Deductible ____________ Max. Annual Benefit ____________
Orthodontic Coverage? ☐ yes ☐ no

Additional Insurance

Insured's Name ____________
Relationship ____________
Birthdate ____________ Soc. Sec. No. ____________
Employer ____________ Date Employed ____________
Occupation ____________
Insurance Company ____________
Group No. ____________ Emp. No. ____________
Ins. Company Address ____________
Deductible ____________ Max. Annual Benefit ____________
Orthodontic Coverage? ☐ yes ☐ no

over please