WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form completely. If you have questions we'll be glad to assist you. We look forward to working with you in maintaining your child's dental health.

Date _____

Child Patient Information

Name of Minor/Child _____
Last Name First Name Initial Nickname

Sex ☐M ☐F Age ____ Birthdate _____ Hobbies _____

Home Address _____
Street City State Zip

Responsible Party residing with Minor/Child _____

Home Phone _____ Responsible Party's Work Phone _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work

Name of person, insurance, or office referring you to our practice: _____

Insurance

Do you have dental insurance coverage for minor/child? Yes No

Primary Insured's Name _____

Address (if different from patient) _____

_____

Home Phone _____ Work Phone _____
(if different from above)

Employer/Plan Name _____

Soc. Sec. # _____ Birthdate _____

Ins. Company _____

Claim Address _____

_____

Policy # _____ Group # _____

Phone No. _____

Secondary Insured's Name _____

Address (if different from patient) _____

_____

Home Phone _____ Work Phone _____
(if different from above)

Employer/Plan Name _____

Soc. Sec. # _____ Birthdate _____

Ins. Company _____

Claim Address _____

_____

Policy # _____ Group # _____

Phone No. _____

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request and
Name of Minor/Child
authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and fluoride, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Responsible Party