



PEDIATRIC DENTISTRY

JOSEPH A YALE, DDS

KATIE McGLENDON, DDS

(225) 664-2646 • (225) 664-2640 (fax)

245 VETERANS BLVD. • DENHAM SPRINGS, LA 70726

1

Tell Us About Your Child

Today's Date: _____ Child's Name: _____
First Middle Last
Nickname: _____ M F Birthdate: ____/____/____
Billing Address: _____ City: _____ St: _____ Zip: _____
Age: _____ SSN: _____
School: _____ Grade: _____
E-Mail Address: _____

2

Who is Accompanying Your Child Today?

Name: _____ Relation: _____
Do you have legal custody of this child? Yes No
Whom may we thank for referring you? _____
List other family members seen by us _____

3

Parent Information

Mother Stepmother Guardian
Name: _____ Birthdate: ____/____/____
Cell #: (____) ____-____ Home #: (____) ____-____ Work #: (____) ____-____
Employer: _____ SSN: _____
 Father Stepfather Guardian
Name: _____ Birthdate: ____/____/____
Cell #: (____) ____-____ Home #: (____) ____-____ Work #: (____) ____-____
Employer: _____ SSN: _____
Parent's Marital Status: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED
If foster parent, provide case worker: Name: _____ Ph #: (____) ____-____

4

Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Ph. #: (____) ____-____ Group #: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____ I.D. # _____
Policy Owner's Employer: _____
*If child does not have dental insurance, how do you intend to pay? Cash Check MC / VISA / Discover