
# PEDIATRIC DENTISTRY

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## 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 siblings seen by our office _____

_____

## 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