

WELCOME

1

About Your Child

Today's Date: ____/____/____ File #: _____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ Boy Girl

Child's Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Child's Home Phone #: (_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

3

Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? Yes No

How many Brothers/Sisters? _____ Age(s): _____

Mother's Name: _____
 STEP MOTHER GUARDIAN

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) _____ (_____) _____
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
 STEP FATHER GUARDIAN

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) _____ (_____) _____
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

2

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Does either policy cover Orthodontics? Yes No

Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

4

Account Information

Person ultimately responsible for account

Name: _____ RELATION TO CHILD

Billing Address: _____

CITY STATE ZIP

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____) _____ (_____) _____
WORK PHONE #: EXT. CELL PHONE #:

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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