



WELCOME

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

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex M F Age _____
 Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
 Street City State Zip

Mailing Address _____
 Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above) E-mail _____ Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (____) _____ Address _____ Group # _____ Policy # _____ Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No Child's Medical Assistance I.D. # _____	Mother's/Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above) E-mail _____ Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (____) _____ Address _____ Group # _____ Policy # _____
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DENTAL HISTORY

Date of last visit to a dentist _____	For what service? _____																											
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