

Welcome to our practice!

Patient ID No. _____

Today's date _____

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name _____

Nickname _____ Sex _____

E-mail _____

Birthdate _____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

City _____

State/Province _____ Zip/Postal Code _____

Phone _____

Mother Stepmother Guardian

Name _____

E-mail _____

Home Phone _____

Work Phone _____

SS#/SIN _____

Employer _____

Occupation _____

Father Stepfather Guardian

Name _____

E-mail _____

Home Phone _____

Work Phone _____

SS#/SIN _____

Employer _____

Occupation _____

Parent/Guardian's Marital Status

Single Married

Divorced Widowed Separated

Who is responsible for making appointments?

Name _____

E-mail _____

Home Phone _____

Cell Phone _____

Work Phone _____

Best time to call (time) _____ (days) _____

Responsible Party

Name _____

E-mail _____

Relationship _____

Address _____

SS#/SIN _____

Primary Dental Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group No. _____ Emp. No. _____

Ins. Company Address _____

Deductible _____ Max. Annual Benefit _____

Orthodontic Coverage yes no

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group No. _____ Emp. No. _____

Ins. Company Address _____

Deductible _____ Max. Annual Benefit _____

Orthodontic Coverage yes no

over please



