WELCOME

Tell Us About Your Child

Today's Date: ____/____/____ Nickname: ______________

Child's Name: ________________________________
Last First MI

Child's Birthdate: ____/____/____ Age: ________ ☐ Male ☐ Female

E-mail Address: ______________

School: ______________ Grade: ______________

Hobbies/Sports: ______________

Child's Home #: (____) ______________ SS #: ______________

Child's Home Address: ______________
Apt / Condo #

____
City State Zip

General Information

Who is accompanying the child today?

Name: ______________ Relation: ______________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? ______________

Other siblings: ______________

General Dentist: ______________ Last Visit Date ______________

Dentist's Phone #: (____) ______________

Relative or Friend not living with you:

Name: ______________ Phone: (____) ______________

Address: ______________

____
City State Zip

Parent's Information

Who is responsible for account? ______________ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Father ☐ Step Father ☐ Guardian

Name: ______________ Birthdate: ____/____/____

Address: (If different than Child's)

____

____

SS #: ______________ DL #: ______________

Wk #: (____) ______________ Ext: ______ Hm #: (____) ______________

Email: ______________ Cell #: (____) ______________

Employer: ______________ Occupation: ______________

Employer's Address:

____
City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: ______________

Insurance Address: ______________

____
City State Zip

Insurance Phone: (____) ______________

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

☐ Mother ☐ Step Mother ☐ Guardian

Name: ______________ Birthdate: ____/____/____

Address: (If different than Child's)

____

____

SS #: ______________ DL #: ______________

Wk #: (____) ______________ Ext: ______ Hm #: (____) ______________

Email: ______________ Cell #: (____) ______________

Employer: ______________ Occupation: ______________

Employer's Address: ______________

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City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

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City State Zip

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

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________ ______________
Signature of Parent or Guardian Date

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