PATIENT INFORMATION

Computer #_____ Office: _____ Today's Date: _____

Male _____ Female _____ Dentist: _____

First: _____ Last: _____

Address: _____E mail:_____

City: _____ State: _____ Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Birthdate: _____

Exam Date: _____ School: _____ Referred by: _____

FAMILY INFORMATION

The following information is requested so that we can communicate properly with the people involved with your child's treatment.

If the parents do not reside together, which parent has primary responsibility? _____

Are the parents separated? ___yes ___no Divorced? ___yes ___no Remarried? ___yes ___ no

Who should receive routine information about treatment progress? _____

Patient's Parent - Mr. / Mrs. / Ms. / Dr.

Last name _____ First name _____

Home phone _____ SS# _____

Address_____ City_____ State _____ Zip _____

Parent's occupation _____ Work Phone _____ Cell Phone:_____

Name of Employer _____ City _____

Patient's Parent - Mr. / Mrs. / Ms. / Dr.

Last Name _____ First name _____

Home phone _____SS#_____

Address_____ City _____ State _____ Zip _____

Parent's occupation _____ Work Phone _____Cell Phone:_____

Name of employer _____ City _____

Other adults we should know about

Last name _____ First name_____

Relationship to Patient_____

Home phone _____ Work Phone _____

Last name _____ First name _____

Relationship to Patient_____

Home phone _____ Work Phone _____

Patient's siblings

Names Ages Schools

Insurance/Other Information

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

	Name of Policy Holder	Birthdate	Insurance company name
1.	_____	_____	_____
2.	_____	_____	_____