PATIENT INFORMATION

❒ MALE ❒ FEMALE

CHILD'S FULL NAME ____________________ Preferred Name ____________

DATE OF BIRTH ____________ SS# ____________ SCHOOL NAME ____________________

HOBBIES or INTERESTS or PETS ________________________________

SIBLINGS' NAMES ________________________________

RESPONSIBLE PARTY INFORMATION

Mother / Legal Guardian	Father / Legal Guardian
Name ____________________	Name ____________________
SS # ____________ Date of Birth ____________	SS # ____________ Date of Birth ____________
	❒ check here if the address & home ph # are the same
Address ____________________	Address ____________________
____________________ City State ZIP	____________________ City State ZIP
Email: ____________________	Email: ____________________
Ph H ( ) ____________ Wk ( )____________	Ph H ( ) ____________ Wk ( )____________
Cell ( ) ____________________	Cell ( ) ____________________
Occupation ____________________	Occupation ____________________
Employer ____________________	Employer ____________________
Dental Insurance No Yes ❒ check here if Primary	Dental Insurance No Yes ❒ check here if Primary

PRIMARY DENTAL INSURANCE ____________________ GROUP # ____________ ID# ____________

SECONDARY DENTAL INSURANCE ____________________ GROUP # ____________ ID# ____________

Special family considerations of which we should be aware: ____________________

How did you hear about our practice? ____________________

Does this person have a child in our practice? Y N

Emergency contact (other than parent): ____________________

Name Relationship to Child Phone #

I understand I am responsible for payment of dental services and the fees are due the day of service. I understand balances remaining 30 days from date of service will be assessed a finance charge (18% annually). I agree to pay all collection and legal costs should this account become default. I understand that dental insurance is a method of sharing the cost of dental services but the fee for services is ultimately my responsibility. Returned checks or charge backs incur a $30.00 fee. If a pattern of cancellation develops or I fail to show for an appointment, I understand my child will be referred to another office for care.

Signature ____________________ Date ____________