Child New Patient

Tell Us About Your Child

Today's Date: ___/___/___ Nickname: _____

Child's Name: _____

First Last MI

E-Mail Address: _____

SS #: _____ Birthdate: ___/___/___ Age: _____ ☐ Male ☐ Female

School: _____

Grade: _____ Hobbies/Sports: _____

Child's Home #: (____)_____

Child's Home Address: _____

_____

City State ZIP

Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ yes ☐ no

Whom may we thank for referring you? _____

List brothers/sisters with age: _____

_____

General Dentist: _____ Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

☐Mother's Information ☐ Step Mother ☐ Guardian

Name: _____

Birthdate: ___/___/___ HM #:(____)_____ WK #:(____)_____ Ext: _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

☐ Father's Information ☐ Step Father ☐ Guardian

Name: _____

Birthdate: ___/___/___ HM #:(____)_____ WK #:(____)_____ Ext: _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____

City State ZIP

Previous Address: _____

_____

City State ZIP

HM #:(____)_____ DL #: _____

Employer: _____

WK #:(____)_____ Ext: _____ SS #: _____

Who is responsible for making appointments?_____

HM #:(____)_____ WK #:(____)_____ Ext: _____