Pediatric Dentistry

The information below must be filled out completely by a parent or guardian. If you do not have the legal right to fill out this form, please inform the front desk.

FAMILY INFORMATION SHEET

Date _____ Patient(s) names(s) _____
Other children under age 18 _____

GUARDIAN INFORMATION

Father's Name_____
E-mail Address _____
Birth date _____/_____/_____
Address_____
PO BOX _____
City _____State_____Zip_____
Phone #_____
Cell Phone # _____
Social Security # _____
Employer _____
Employer's Phone # _____
Employer's Address _____

Mother's Name_____
E-mail Address: _____
Birth date_____/_____/_____
Address _____
PO BOX _____
City_____State_____Zip_____
Phone #_____
Cell Phone #_____
Social Security #_____
Employer _____
Employer's Phone #_____
Employer's Address _____

Primary Dental Insurance Info.
Insurance Company_____
Policyholder _____
ID # _____

Secondary Dental Insurance Info.(if applicable)
Insurance Company_____
Policyholder_____
ID # _____

Person to contact in case of emergency _____
Address _____
Phone #_____ Relationship_____

How did you hear about us? (Please circle one or indicate name)

Internet Search/Google Our Building Sign Our Website Facebook

Friend_____ Family_____

Dentist/Doctor_____ Other_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

By signing this form you are taking responsibility for your child's account with this office and any charges incurred from provided services.

Name of Parent/Guardian:_____Relationship:_____

Signed: _____ Date: _____

In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services.