



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

Marital Status of Guardians: Married Divorced Single Other

Father's Name Mother's Name
E-mail Address E-mail Address:
Birth date Birth date
Address Address
PO BOX PO BOX
City State Zip City State Zip
Phone # Phone #
Cell Phone # Cell Phone #
Social Security # Social Security #
Employer Employer
Employer's Phone # Employer's Phone #
Employer's Address Employer's Address

Primary Dental Insurance Info. Secondary Dental Insurance Info.(if applicable)
Insurance Company Insurance Company
Policyholder Policyholder
ID # 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.