PATRICE ESPINOSA, D.D.S. ● Pediatric Dental Specialist
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GET ACQUAINTED QUESTIONNAIRE

Last Name _____ **First Name(s)** _____

Birth Date: _____ Age: _____ Sex: M / F Name of School: _____ Grade _____
Home Address _____
Street **City / State / Zip**
Father's Name _____ Email Address _____
Home Address (if different from above) _____
Phone ( ) _____ (home / cell) Phone ( ) _____ (cell / work)
Date of Birth _____ Employer/Occupation_____
Mother's Name _____ Email Address _____
Home Address (if different from above) _____
Phone ( ) _____ (home / cell) Phone ( ) _____ (cell / work)
Date of Birth _____ Employer/Occupation _____

With whom does child reside? ☐ Father ☐ Mother ☐ Other _____

Person responsible for the account
☐ Father ☐ Mother ☐ Other (If Other, please complete the next section)
Last Name _____ First Name _____ Middle Initial _____
Relationship _____ Email _____
Phone ( ) _____ (home / cell) Phone ( ) _____ (cell / work)
Address: _____
Street **City / State / Zip**

Which one of our patients should we thank for referring you to our practice?
Last Name _____ First Name _____

Dental Insurance Information
Dental Insurance Company _____
Who is the Subscriber? _____
Subscriber's SSN _____ Subscriber DOB _____
Membership/Enrollee ID # _____ Secondary Insurance? Y / N

I hereby authorize my dentist to release any and all dental information to the dental insurance company for purposes of claims administration and authorization.

I understand that I am responsible for any charges for treatment my child receives in this office. Balance is due within 30 days of treatment. Late payments will be subject to Collections Agency.

Parent's Signature _____ **Date** _____

For Office Use Only: First Visit Y / N ● Last Visit _____ ● Is child in pain Y / N ● Which tooth T / B L / R ● Continuous pain Y / N ● Meds Help Y / N ● Previous Dentist _____