

Patient ID# \_\_\_\_\_

Today's Date \_\_\_\_\_

# Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

## Your Child

Child's Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_  
Email \_\_\_\_\_

### Mother

Stepmother  Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
DL # \_\_\_\_\_

### Father

Stepfather  Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
DL # \_\_\_\_\_

## Primary Dental Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Emp. \_\_\_\_\_  
Occupation \_\_\_\_\_

Ins. Company \_\_\_\_\_ Group # \_\_\_\_\_ Emp. # \_\_\_\_\_  
Ins. Company Address \_\_\_\_\_  
Deductible \_\_\_\_\_ Amount already used \_\_\_\_\_ Max. annual benefit \_\_\_\_\_  
Orthodontic coverage  Yes  No

## Additional Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Employer \_\_\_\_\_  
Date Emp. \_\_\_\_\_ Occupation \_\_\_\_\_  
Ins. Company \_\_\_\_\_ Group # \_\_\_\_\_ Emp. # \_\_\_\_\_  
Ins. Company Address \_\_\_\_\_  
Deductible \_\_\_\_\_ Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Parent's Marital Status

Single  Divorced  
 Married  Widowed  
 Separated

## Who is responsible for making appointments?

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Best time to call (Time) \_\_\_\_\_ (Days) \_\_\_\_\_  
Over Please