PATIENT INFORMATION

Child's Name____**Nickname:**__________________

Gender: ☐ **M** ☐ **F**

Residence Address: ____

Date of Birth: ______________ **Age:** _______

Child Resides with: _____________________ **Relationship to Child:** __________________________

Preferred Contact #: ( ) _________________________

Is He/She involved in any extracurricular activities? ☐ **Yes** ☐ **No**

If so, what?____

Father's/Legal Guardian's Name:________________________________**Date of Birth:**_______________

Residence Address (if different from child's)

____

Home: ( ) _________________________ **Mobile: ( )** ________________________

E-mail Address: ____

Employed by: ____

Social Security# ________-________-________ (required, if you'd want us to bill your insurance company)

Dental Insurance Carrier: ______________________________ **Group #:**___________________________

Address: ____

Phone: ( )_____________________

Mother's/Legal Guardian's Name: _______________________________**Date of Birth:**________ ______

Residence Address (if different from child's)

____

Home: ( )______________________ **Mobile: ( )**_________________________

E-mail Address: ____

Employed by: ____

Social Security# ________-________-________ (Required, if you'd want us to bill your insurance company)

Dental Insurance Carrier: ______________________________ **Group #:**_________________________

Phone: ( )______________________

Whom may we thank for referring your child to our practice?

____

NAME RELATIONSHIP

Whom may we call in case of an emergency?

____

NAME RELATIONSHIP PHONE #