Tell Us About Your Child

Child's Name: _____
First Last Mi

Nickname: _____ Sex: M F Age:_____

Birthdate: ____/____/____ Phone #: (_____) _____

Address: _____

_____
City State Zip

Child lives with: Mother Father Step-Parent Other _____

School: _____ Grade: _____

Hobbies/Interests: _____

Dentist Name: _____ Last Visit _____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Y N

Whom may we thank for referring you? _____

_____

List any family members seen by us (past or present)

_____

Parental Information

Mother

Name _____ Birthdate ____/____/____

Phone #:(H) _____ (Wk/Cell)_____

Address: _____

Employer: _____ Years of Service? _____

Occupation: _____

Marital Status: Single Married Divorced Widowed Partnered

Father

Name _____ Birthdate ____/____/____

Phone #:(H) _____ (Wk/Cell) _____

Address: _____

Employer: _____ Years of Service? _____

Occupation: _____

Marital Status: Single Married Divorced Widowed Partnered

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Years There _____ Own Home ___ Rent Home ___

Birthdate: _____ E-mail: _____

S.S. # _____ Phone #: (H) _____

Who is responsible for making appointments?

Name: _____ Relation: _____

Phone #: (H) _____ (Wk/Cell) _____

Participate in one of the following HSA FSA

Insurance

Dental Coverage Y N Orthodontic Coverage Y N

Primary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group Name: _____ Group #: _____

Policy Owner's Name: _____

Policy Owner's SS/ID#: _____ Birthdate: _____

Relationship to patient: _____

Policy Owner's Employer: _____

Is the patient covered by another Orthodontic Policy? Y N

Secondary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group Name: _____ Group #: _____

Policy Owner's Name: _____

Policy Owner's SS/ID#: _____ Birthdate: _____

Relationship to patient: _____

Policy Owner's Employer: _____