WELCOME!

Tell Us About Your Child

Today's Date: ______ ❑ Male ❑ Female

Child's Home Phone #: (____)______ Child's Age: ______

Child's Birthdate: ___/___/___ Social Security #: ______

Child's Name: ______
Last First MI

Nickname: ______

Hobbies: ______

School: ______ Grade: ______

Child's Home Address: ______
Street

______
City State Zip

Who Is Accompanying The Child Today?

Name: ______ Relation: ______

Do you have legal custody of this child? ❑ Yes ❑ No

Is the child adopted? ❑ Yes ❑ No Is the child in a foster home? ❑ Yes ❑ No

Whom may we Thank for referring you? ______

Other siblings seen by us: ______

Neighbor or Relative not living with you

His / Her Name: ______ Relation: ______

Work Phone #: (____)______ Home Phone #: (____)______

Address: ______
Street

______
City State Zip

Parent's Information

Parent's Marital Status: ❑ Married ❑ Partnered ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single

Mother: ❑ Step Mother ❑ Guardian Birthdate: ___/___/___ Home Phone #: (____)______ Work Phone #: (____)______

Name: ______ Social Security #: ______ Driver's License #: ______

Address: ______
Street City State Zip

Employer: ______ Length of Employment: ______

Father: ❑ Step Father ❑ Guardian Birthdate: ___/___/___ Home Phone #: (____)______ Work Phone #: (____)______

Name: ______ Social Security #: ______ Driver's License #: ______

Address: ______
Street City State Zip

Employer: ______ Length of Employment: ______

Person Responsible for Account

Name: ______ Relationship: ______ Social Security #: ______

Billing Address: ______
Street City State Zip

Work Phone #: (____)______ Home Phone #: (____)______ Employer: ______ Driver's License #: ______

Who is responsible for making appointments?

Name: ______ Work Phone #: (____)______ Home Phone #: (____)______ Best time to call: ______

Insurance Information

Primary

Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______ Phone #: (____)______ Group # (Plan, Local, or Policy #): ______

Insurance Co. Address: ______
PO Box/Street City State Zip

Policy Owner's Name: ______ Relationship to Patient: ______

Policy Owner's Birthdate: ___/___/___ Social Security #: ______ Policy Owner's Employer: ______

Employer's Address: ______
Street City State Zip

Secondary

Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______ Phone #: (____)______ Group # (Plan, Local, or Policy #): ______

Insurance Co. Address: ______
PO Box/Street City State Zip

Policy Owner's Name: ______ Relationship to Patient: ______

Policy Owner's Birthdate: ___/___/___ Social Security #: ______ Policy Owner's Employer: ______

Employer's Address: ______
Street City State Zip

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