

Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Name _____ Birthday _____

Age _____ Nickname _____ Sex M F

Home Address _____

City _____ State _____ Zip _____

Phone# ____/____/____

INSURANCE

Parents/Guardian's Name _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone# ____/____/____ E-mail _____

Employer _____ Soc. Sec# _____

Insurance Company _____

Insurance Phone# ____/____/____ Group# _____

Contract# _____ Birthday ____/____/____

Secondary Insurance Company _____

Employer _____ Soc. Sec# _____

Insurance Company _____

Insurance Phone# ____/____/____ Group# _____

Contract# _____ Birthday ____/____/____