

Patient Information Form

Patient(s) Last name _____

Address _____

City _____ Zip Code _____

Child 2 First name _____

Nickname _____

Birth date _____ Sex: M F

Child 1 First name _____

Nickname _____

Birth date _____ Sex: M F

Child 3 First name _____

Nickname _____

Birth date _____ Sex: M F

Responsible Party

With whom does patient live? _____ Person responsible for account? _____

Who brought patient today? _____ Does patient have dental insurance? _____

Parent or Guardian Information

___ Mother ___ Stepmother ___ Guardian

Name _____

Address _____

City _____ Zip Code _____

Mobile # _____

Home # _____

Work # _____

Email _____

___ Father ___ Stepfather ___ Guardian

Name _____

Address _____

City _____ Zip Code _____

Mobile # _____

Home # _____

Work # _____

Email _____

Primary Insurance

Name of insured parent _____

Date of birth _____

ID number or SSN _____

Employer _____

Carrier _____

Group # _____

Secondary Insurance

Name of insured parent _____

Date of birth _____

ID number or SSN _____

Employer _____

Carrier _____

Group # _____

Whom may we thank for referring you to our office? _____

I have reviewed the information on this form and it is accurate to the best of my knowledge.

I also acknowledge that the Dental Materials Fact Sheet has been made available to me.

Signature of Parent/Guardian

X _____ Date _____