

**Patient Information Form**  
**Anne R. Lee, DDS Pediatric Dentistry**

**Patient's Last name** \_\_\_\_\_ **First name** \_\_\_\_\_  
Nickname \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M F  
Address \_\_\_\_\_ School \_\_\_\_\_  
\_\_\_\_\_ Grade \_\_\_\_\_

**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 \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Driver's license no. \_\_\_\_\_  
\_\_\_\_\_ Employer \_\_\_\_\_  
Phone: Mobile \_\_\_\_\_ Title \_\_\_\_\_  
Home \_\_\_\_\_ Work phone \_\_\_\_\_

\_\_\_ Father \_\_\_ Stepfather \_\_\_ Guardian

Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Driver's license no. \_\_\_\_\_  
\_\_\_\_\_ Employer \_\_\_\_\_  
Phone: Mobile \_\_\_\_\_ Title \_\_\_\_\_  
Home \_\_\_\_\_ Work phone \_\_\_\_\_

**Primary Insurance Carrier** \_\_\_\_\_ Name of insured \_\_\_\_\_  
Contract no. \_\_\_\_\_ Group no. \_\_\_\_\_

**Secondary Insurance Carrier** \_\_\_\_\_ Name of insured \_\_\_\_\_  
Contract no. \_\_\_\_\_ Group no. \_\_\_\_\_

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 authorize and request my insurance company to pay directly to the dentist insurance benefits. Furthermore, I understand that, even though I may have dental insurance, I am responsible for all financial obligations that may arise as a result of any dental treatment provided for my child.*

**Signature of Parent/Guardian**

X \_\_\_\_\_  
Date \_\_\_\_\_