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

Date:_____

Name of Minor/Child_____

Sex: M___F___ Age:_____ Birthdate:_____ Social Security Number:_____

Home Address_____

Mailing Address_____

Person financially responsible_____

Home phone_____ Work phone_____Cell phone_____

Whom may we thank for referring you?

_____

Parent's Information

Father's/Guardian's name_____ Address (if different from patient's)_____ _____ Employer_____ Soc.Sec.#_____Birthday_____ Do you have dental insurance for minor child Yes___No____	Mother's/Guardian's Name_____ Address (if different patient's)_____ _____ Employer_____ Soc.Sec#_____Birthday_____ Do you have dental insurance for minor child Yes___No___
Plan Name_____	Plan Name_____
Phone Number_____ Address_____ _____ Group#_____ Policy#_____	Phone Number_____ Address_____ _____ Group#_____ Policy#_____