WELCOME TO OUR OFFICE

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank you and we are glad you are here!

ABOUT CHILD

Today's Date: _____ **Patient's Name:**_____
Last First MI

Date of Birth: _____-_____-_____ Age:_____ Preferred Name:_____ Male Female

How did you hear about our office? _____

Mother's Information Use as primary contact information for patient Yes ( ) No ( )

Name : _____ Phone (h) (_____)_____-_____
first and last

Address:_____ (w) (_____) _____-_____

City: _____State: _____Zip:_____ c) (_____) _____-_____

DOB:____-_____-_____SSN:_____ **Can we text appointment information to your cell phone? Y N**

Email address:_____

Father's Information Use as primary contact information for patient Yes ( ) No ( )

Name: _____ Phone (h) (_____)_____-_____
first and last

Address: _____ (w) (_____) _____-_____
IF DIFFERENT FROM ABOVE

City: _____State: _____Zip:_____ (c) (_____) _____-_____

DOB: _____-_____-_____SSN:_____ **Can we text appointment information to your cell phone? Y N**

Email address:_____

DENTAL INSURANCE INFORMATION

Name of **Employee**: _____ Name of **Employer**: _____

Employee's ID# or SSN: _____ Insurance Co. Name: _____

Employee's DOB: _____-_____-_____ Address: _____

Group #: _____ _____

Phone # for customer service :(_____)_____-_____

DENTAL HISTORY

Why has your child come to the dentist today? _____

How long since their last dental visit? _____ Name of previous dentist:_____

Has patient had orthodontic treatment in the past? Yes No Do they currently wear any retainers or nightguards? Yes No