CHILD PATIENT INFORMATION

(Please feel free to ask if you have questions)

REFERRAL SOURCE

Name of person who told you about us ______________________________
Yellow Pages? ☐ Which One? ______________________________
Other? ______________________________

What do you expect from us today? ______________________________

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Why did you leave your last dentist? ______________________________

____

What did you like least about any previous dentist? ______________________________

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What did you like most about any previous dentist? ______________________________

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PATIENT INFORMATION

Name ______________________ Date of Birth ______________________ Male/Female (circle one)

RESPONSIBLE PARTY INFORMATION

Name ______________________ Social Security# ______________________
Address ______________________ Phone (H) ____________ (W) ____________
City/State ______________________ How long at this address? ______________________
Zip ______________________ Date of Birth (DOB) ______________________
Employer ______________________ How long? ______________________
Employer Address ______________________________
Insurance Company ______________________ Agreement/Policy # ______________________
Group # ______________________ Union ______________________
Spouse ______________________ Social Security# ____________ DOB ____________
Employer ______________________ How long? ______________________
Insurance Company ______________________ Agreement/Policy # ______________________
Group # ______________________ Union ______________________

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate.

Signed ______________________ **Date** ______________________

(over please-medical history on back)