WELCOME to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach oral habits which will help keep your child's smile beautiful for their lifetime.

YOUR CHILD

Child's Name _____

Nickname _____

Date of Birth ____/___ / _____Age_____

School _____

Sex: M_____ F_____

Child's mailing address _____

_____

Phone # _____

RESPONSIBLE PARTY

Name _____

Relationship _____

Mailing Address _____

_____

Physical Address_____

_____

_____

Home phone # _____

Cell phone # _____

Work phone # _____

DENTAL INSURANCE

Insured's Name _____

Insured's Employer _____

Relationship _____

Date of Birth _____

Insurance Company _____

Group # _____

Social Security #_____

Employer _____

Occupation _____

SSN#_____

In the event of an emergency, who should we contact?

Name _____

Relationship _____

Phone number _____

Who can we thank for referring you to us?

_____

FINANCIAL ARRANGEMENTS

Our office will make every effort to provide the best care for your child. You can help us by paying for dental services upon completion of each visit. **IF YOU HAVE INSURANCE, WE WILL BE HAPPY TO COMPLETE YOUR INSURANCE FORM, BUT PLEASE REMEMBER THAT YOU ARE ULTIMATELY RESPONSIBLE FOR ALL SERVICES PERFORMED ON YOUR DEPENDENT.** ***THANK YOU!***

X _____ _____

Signature of Parent / Guardian **Date**