Referring Dentist ______________________ Today's Date________________

Patient Name ____
Last First MI

Patient Date of Birth ___________ Age ___ Social Security # ______________

Patient Address ____
Street name & number City State Zip
Patient Home Phone# ____________ Patient Cell #______________ Male or Female

Father's Name ____
Last First MI
Father's Address ____
Street City Zip
Father's ____
Date of Birth SSN# Employer
Father's ______________ _________________ ______________
Home Phone# Cell # Work #

Mother's Name ____
Last First MI
Mother's Address ____
Street City Zip
Mother's ____
Date of Birth SSN# Employer
Mother's ______________ _________________ ______________
Home Phone # Cell # Work#
Name and telephone number of a relative of friend NOT LIVING WITH YOU we can reach as an emergency contact or if we can not reach either parent_________________

Method of Payment Today: _______ Cash _______Credit/Debit Card _______Check
DENTAL INSURANCE INFORMATION: Subscriber_________ Relationship ______
ID# ____________________ Group#______________ Employer__________
Insurance Co Name ______________________ Phone # _________________
Insurance Co Address ______________ ______________ ____________
Street City & State Zip

THE PARENT WHO IS PRESENT WITH THE CHILD AND REQUESTS TREATMENT IS THE PERSON RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED IN THIS OFFICE.

____ _______________
Signature of Parent Requesting Treatment **Date**