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Date _____

## 1 About Your Child

Child's Name: _____
LAST FIRST M.I.

Birthday: _____ Age: _____ Gender: _____

Address: _____

City _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Physician Name: _____

School Name: _____ Grade: _____

Musical Instruments Played: _____

Sports Played: _____

## 2 Child's Family Information

**Father's Name** _____
Stepfather Guardian

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____
Birthday: _____ Age: ____ Marital Status: ___

S.S.#: _____

Employer: _____
Position: _____
Address: _____
City: _____ State: _____ Zip: _____

**Mother's Name:** _____
Stepmother Guardian

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____
Birthday: _____ Age: ____ Marital Status: _____

S.S.#: _____

Employer: _____
Position: _____
Address: _____
City: _____ State: _____ Zip: _____

## 3 Insurance Information

Primary Dental Insurance

Co. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Group #: _____
Relationship to patient: _____

Secondary Dental Insurance

Co. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone # _____
Group #: _____
Relationship to patient: _____