

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Employer: \_

DL #:

SS #:\_

Please fill out this form completely. The better we communicate, the better we can care for you.

CONTINUED ON BACK

Tell Us About Your Child Today's Date:	Person Responsible For Account
Child's Name:	Billing Address:
Nickname:	
hild's Birthdate: / / Child's Age:	Wk #: () Ext: Hm #: ()
chool: Grade:	DI #: SS #:
hild's Home #: ( SS #:	Who is responsible for making appointments?
hild's Home Address:	Name:
	Wk #: ( Ext: Hm #: ()
CHY STATE ZIP	
Plation:	Insurance Co. Name:
Whom may we <b>Thank</b> for referring you:	
other family members seen by us:	
	Policy Owner's Name:
revious / Present Dentist:	Relationship to patient:
st visit date:	Policy Owner's Birthdate:/ SS #:
arent's Marital Status: 🖵 Single 🖾 Warnied 🗀 Widowed 🗀 Divorced 🗀	Folicy Owner's Employer:
	Orthodontic coverage? ☐ Yes ☐ No
Mother's Information Step Mother	Constitue
	Secondary Dental Insurance
Name: Birthdate:/	
vk #: () Ext: Hm #: ()	Francisco Co. N. Co.
nployer:	Insurance Co. Address:
S#:DL#:	
	Group # (Plan, Local, or Policy #):
Father's Information Step Father Guardia	
Name: Birthdate:/_	
	Policy Owner's Righdate: / / SS #-

Policy Owner's Employer: \_

Orthodontic coverage? Yes No

