Child Patient Information

| Last Name: | First Name: | M.I: | Nickname: |
|---|---|---|---|
| Mailing Address: | | City/State/Zip | |
| Sex: M F | Date of Birth: | Social Security Number: | Home Phone Number: |

Parent/Guardian/Responsible Party Information

| Last Name: | First Name: | Middle: |
|---|---|---|
| Mailing Address: | City/State/Zip | |
| Sex: M F / Date of Birth: | Social Security Number: | Home Phone Number: |
| Employer: | Work Phone Number: | Cell/Alternate Phone Number: |

Dental Insurance Information

| Name of Insured Party: | Relationship to Patient: □ Self □ Spouse □ Child □ Other | |
|---|---|---|
| Social Security Number: | Date of Birth: | Employer/Group Name: |
| Employer Phone Number: | Insurance Company Name: | Insurance Company Phone Number: |
| Insurance Company Address: | Member I.D. | Group Number: |

| Emergency Contact Name: | Phone Number: |
|---|---|
| Referral Information:<br>□ Patient:_____ □ Employee_____ □ Yellow Pages □ Television<br>□ Radio □ Magazine □ Other_____ | |

# CHILD INFORMATION