the kids dentist

Tell Us About Yourself

Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ Email: _____
Street Address City State Zip

Cellular Phone: _____ Secondary Phone: _____

Previous dentist: _____ Last Visit Date: _____

Primary Care Physician: _____

Employer: _____ Occupation: _____ SSN: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Prefer not to answer

Primary Dental Insurance

Insurance company name: _____ Group: _____ Phone: _____

Insurance company mailing address: _____
Street Address City State Zip

Policy owner's name: _____ DOB: _____ ID: _____

Policy owner's SSN: _____ Relationship to patient: _____

Policy owner's employer: _____

Secondary Dental Insurance

Insurance company name: _____ Group: _____ Phone: _____

Insurance company mailing address: _____
Street Address City State Zip

Policy owner's name: _____ DOB: _____ ID: _____

Policy owner's SSN: _____ Relationship to patient: _____

Policy owner's employer: _____

Other

Purpose of today's visit: _____

Are you currently having any pain? _____

Do you vape, smoke, or use other tobacco products? _____

Please list any habits that may stain your teeth (tea, coffee, red wine): _____

Do you have concerns about the color/shade of your teeth? _____

Do you have concerns about the alignment of your teeth? _____

Describe any unusual reactions during/after dental treatment? _____

Are you currently seeing an orthodontist or other dental specialist? _____

Is there anything else we should know for this appointment? _____

I hereby grant permission to the staff of this office for the administration of such anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information as answered on this form is correct to the best of my knowledge.

I understand that I am financially responsible for the payment of any services rendered as well as broken appointment fees and all late payment service charges. Should I have dental insurance, I also understand that obtaining insurance coverage and benefit information as well as keeping up with the ever changing polices of my unique plan is my responsibility.

Signature: _____ Date: _____

Patient name: _____ Date: _____