WELCOME CHILD FORM

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you in maintaining your dental health.

Child Information **Today's Date** ______/_____/______

SS#______________________________

Name____ Nickname____________________
Address____ Apt. #___________
City__________________________________ State___________ Zip ___________

School__________________________________ Grade_____________

Sex [ ] M [ ] F Birth Date___________________________ Age______

Whom may we thank for referring you? ______________________________________

In case of emergency who should be notified? ____________________________________
( ) _______________ Relationship____________________________________

Who is Accompanying the Child Today?

Name____ Relation_____________________________
Do you have Legal Custody of this Child ( ) Yes ( ) No
Is child adopted? ( ) Yes ( ) No Is child in a foster home? ( ) Yes ( ) No

Child's Family Information

Mother's Name_______________________________________ ( ) Step Mother ( ) Guardian
Birth Date ______/______/_____
SS#______________________________ DLC#_________________

Parent's Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Address **(if different from Childs)**
Address____ Apt. #__________
City____ State___________ zip ___________

Home ( ) _______________Cell ( ) _______________ Work_________________ ext_______
Which is the **best** number to contact you at? ( ) Home ( ) Cell ( ) Work
Contacted Text Message ( ) No ( ) Yes
Contacted via email? ( ) No ( ) Yes address____

Employer____________________________________ Occupation_______________________
Address______________________________________ Suite______________
City___________________________________ State___________ Zip________________

Insurance Company_____________________________ Phone #______________________ ext______
Insured ID Number______________________________ Group #__________

(Please Continue on Back)

Father's Name_______________________________ ( ) Step Father ( ) Guardian
SS#_______________________________ DLC#_________________
Birthday_____/_____/______
Parent's Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Address **(if different from Childs)**
Address____ Apt. #__________
City____ State___________ zip ___________

Home ( ) _______________Cell ( ) _______________ Work_________________ ext_______
Which is the **best** number to contact you at? ( ) Home ( ) Cell ( ) Work
Contacted Text Message ( ) No ( ) Yes
Contacted via email? ( ) No ( ) Yes address____

Employer_____________________________________ Occupation___________________________
Address______________________________________ Suite________________
City_________________________________ State___________ Zip_________________

Insurance Company_____________________________ Phone #___________________________ ext______
Insured ID Number_____________________________ Group #__________

Responsible Party
Name of person responsible for this account ____
Relationship to child ____________________

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to TOWN CENTER DENTAL all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all costs of dental treatment.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes to the information I have provided.

Signature____ Date______________________
(Patient, Parent, Guardian or Personal Representative)