ReadySetSmile
Pediatric Dentistry

PATIENT INFORMATION DATE: _____/_____/_____

Full Name: _____ Goes by: _____

Date of Birth: _____/_____/_____ Sex: M or F SS#: _____-____-_____

Street Address: _____

City, State, Zip: _____

Primary Contact Phone Number: _____ School This Child Attends: _____

This Child Lives With: Both Parents Mother Father Legal Guardian

Foster Care Other: _____

PERSON FILLING OUT PAPERWORK

Name: _____ Relationship to patient: _____

*If other than parent, Legal Guardianship paperwork is required before any treatment can be rendered.

PARENTS INFORMATION

Mother's Information:

____Mother ____Step Mother ____Guardian

Name: _____ DOB: ___/___/___

SSN: _____/_____/_____

Address: _____

City, State, & Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Job Title: _____

Father's Information:

____Father ____Step Father ____Guardian

Name: _____ DOB: ___/___/___

SSN: _____/____/_____

Address: _____

City, State, & Zip: _____

Home Phone: _____

Cell Phone:_____

Work Phone: _____

Employer: _____

Job Title: _____

Do you have other children who are already established patients with our practice? YES NO

If yes, name of patient(s) _____

EMERGENCY CONTACT (other than listed above): _____

Relationship to Child: _____ Phone: _____

DENTAL INSURANCE INFORMATION – if this information has not changed since it was last updated you may leave it blank!

Insurance Company: _____ Name of Employer: _____

Policy Number: _____ Group Number: _____

Insurance Phone Number: _____ Name of Policy holder: _____

Address of Policy holder: _____ Contact Phone Number: _____

SS#: _____-_____-_____ Date of Birth: _____/_____/_____

REFERRAL INFORMATION

How did you learn of our office? Insurance Co. Phonebook Advertisement Internet Facebook

Family/Friend: _____ Dr's Office: _____