

WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.
We look forward to working with your child.

PATIENT INFORMATION

Child's Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex M F Age _____ Birthdate _____ School _____
Grade _____ Hobbies/Sports _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Business Phone _____ Cell Phone _____ Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Child _____ Birthdate _____ Soc. Sec. # _____
Address (if different from child) _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____ Insurance Email _____
Insurance Company _____ Phone _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is child covered by additional insurance? Yes No

Subscriber Name _____ Relation to Child _____ Birthdate _____
Address (if different from child) _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____
Business Email _____ Insurance Email _____
Insurance Company _____ Phone _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Please complete both sides.