

# Dentistry for Children

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## PATIENT INFORMATION

(Please Print)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX:  FEMALE  MALE BIRTHDATE: \_\_\_\_\_ S.S.# \_\_\_\_\_

HOME PHONE:( ) \_\_\_\_\_ CELL PHONE:( ) \_\_\_\_\_ OTHER#:( ) \_\_\_\_\_

IF STUDENT, NAME OF SCHOOL: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? \_\_\_\_\_ TELEPHONE:( ) \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

MOTHER/GUARDIAN'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MOTHER/GUARDIAN'S HOME PHONE:( ) \_\_\_\_\_ WORK PHONE#:( ) \_\_\_\_\_ CELL#:( ) \_\_\_\_\_

FATHER/GUARDIAN'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

FATHER/GUARDIAN'S HOME PHONE:( ) \_\_\_\_\_ WORK PHONE#:( ) \_\_\_\_\_ CELL#:( ) \_\_\_\_\_

DO YOU HAVE ANY OTHER CHILDREN WHO ARE PATIENTS OF THIS PRACTICE? IF SO, WHOM? \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ PHONE#:( ) \_\_\_\_\_ WORK PHONE#:( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DRIVER'S LICENSE#: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ S.S.# \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_ EMPLOYER'S ADDRESS: \_\_\_\_\_

## INSURANCE INFORMATION

NAME OF INSURED: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ S.S.#: \_\_\_\_\_ DATE EMPLOYED: \_\_\_\_\_

NAME OF EMPLOYER: \_\_\_\_\_ WORK PHONE#:( ) \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ TEL#:( ) \_\_\_\_\_ GROUP#: \_\_\_\_\_ POLICY#: \_\_\_\_\_

INSURANCE CO. ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO** IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ S.S.# \_\_\_\_\_ DATE EMPLOYED: \_\_\_\_\_

NAME OF EMPLOYER: \_\_\_\_\_ WORK PHONE#:( ) \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ TEL#:( ) \_\_\_\_\_ GROUP#: \_\_\_\_\_ POLICY#: \_\_\_\_\_

INSURANCE CO. ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

X \_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN IF MINOR