

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.