

Smiling Faces Pediatric Dentistry

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PATIENT INFORMATION

Patient's Name: _____ Nick Name: _____
(first) (middle) (last)

Sex: _____ Date of Birth: _____ Age: _____ Phone Number: _____

Home Address: _____
(street / apt.#) (city) (state) (zip)

Father's Name: _____ Social Security Number: _____ - _____ - _____

Father's Date of Birth: _____

Father's Address: _____
(street / apt.#) (city) (state) (zip)

Home Phone: () _____ Email Address: _____

Cell Phone: _____

Employer: _____ Work Phone: _____

Mother's Name: _____ Social Security Number: _____ - _____ - _____

Mother's Date of Birth: _____

Mother's Address: _____
(street / apt.#) (city) (state) (zip)

Home Phone: () _____ Email Address: _____

Cell Phone: _____

Employer: _____ Work Phone: _____

*With whom does the patient live? _____

*Other Children in family and ages? _____

*Dental Insurance: _____ Policy Number: _____

*Who is the guarantor for the insurance? _____

*How did you hear about us? _____ Referred by? _____