



Welcome to Young Dentistry for Children!

Who may we thank for referring you to our practice? _____

***Children/Patients:**

Name _____ (M)(F) DOB _____ Name _____ (M)(F) DOB _____

Name _____ (M)(F) DOB _____ Name _____ (M)(F) DOB _____

***Household Information:**

Name _____

Relationship to Children _____

Marital Status _____

Birthdate _____ SSN # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email Address _____

Employer _____

Name _____

Relationship to Children _____

Marital Status _____

Birthdate _____ SSN # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email Address _____

Employer _____

***Who in the household carries the dental insurance?**

Primary Insured Name _____ Insurance Company _____ Member ID/SSN _____

Secondary Insured Name _____ Insurance Company _____ Member ID/SSN _____

Who will be bringing the children to their appointments, other than their legal guardian and who do you *authorize* to give consent on your behalf?

Name _____ Phone Number _____ Relationship to Patient _____

Name _____ Phone Number _____ Relationship to Patient _____

***We will be communicating with you regarding your children's appointments either by email or text messaging. Which contact method would you prefer us use?
(Please list at least one)**

Text Messaging Number _____ Email Address _____

Signature _____ Relationship to Children _____ Date _____

