primary teeth
pediatric dentistry

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Parent/Legal Guardian Information

First Name:_____Last Name:_____
Cell Phone: ( ) _____ - _____ HomePhone: ( ) _____ - _____
Email:_____
Address:_____
City: _____ State _____ Zip: _____
SSN: _____- _____ - _____ Date of Birth: _____/_____/_____ Age: _____ Sex: ▫ M ▫ F
Relationship to Patient: _____

Additional Contacts/Guardians

First Name : _____ Last Name : _____
Phone Number: _____Relationship :_____

First Name : _____ Last Name : _____
Phone Number: _____Relationship :_____

Child Care Authorization

Will anybody, other than yourself, be bringing your child for future visits?
▫ YES ▫ NO

If yes, who? _____

Financial Agreement

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents/legal guardians are responsible for all fees and services rendered for treatment of a child/dependent. I accept full financial responsibilities for all charges, even if covered by insurance.

Name: _____ Signature:_____ Date: _____/_____/_____