PATIENT INFORMATION - MINOR

Please Print Date___________________________

Patients Legal Name____Preferred Name_____________________M_______F______

Home Address____ City/State/Zip__________________________________

Mailing Address____ City/State/Zip__________________________________

Home Ph# ____________________ Cell #____________________ email __________________Date of Birth______/______/______

SSN ________________________ School_________________________________Grade_________

Person Responsible for Account____________________________________HomePh#__________________Cell #___________________

Home Address____ City/State/Zip__________________________________

Mailing Address____ City/State/Zip__________________________________

SSN ____________________ Date of Birth ______/______/_____Employer__________________________BusTel#_____________

Person to contact in an emergency____ Relationship_______________________

Home Ph#_________________ Bus Ph#__________________ Cell #_________________ Address ________________________

ACCOUNT INFORMATION

Mother's Name____	Father's Name____
___Married ___Single ___Divorced ___Separated ___Widowed	__Married ___Single ___Divorced __Separated ___Widowed
Address____	Address____
City/State/Zip____	City/State/Zip____H
Home Ph# ___________________Cell #___________________	ome Ph# __________________Cell #___________________
Date of Birth _____/______/______ SSN __________________	Date of Birth _____/______/______SSN__________________
Employer____	Employer____
Bus.Ph#____	Bus.Ph#____

Is there step parent information? Yes_____ No_____ If so, please complete the following:

Name____ Employer____

Relationship to patient____________________________________ Bus.Ph#____

Address____ Date of Birth _____/______/______SSN_________________

City/State/Zip____ HmPh#________________________Cell#________________

IS THERE DENTAL INSURANCE THAT WE NEED TO CONSIDER?

Primary:

Insured______________________________________ SSN:________________ ID#__________________DOB_________________

Ins Co ___________________________________ Ph #________________ Group #_________________

Secondary:

Insured______________________________________ SSN:________________ ID#__________________DOB_________________

Ins Co ___________________________________ Ph #________________ Group #_________________

*Are you covered by a third policy?*____

GETTING TO KNOW YOU

Is another member of your family a patient in our office____

Name____Relationship__________________________________