Wright Smiles Pediatric Dentistry

Date _____

Patient Information

Name: _____ Nickname: _____

Birth date: _____ Age: _____ Social Security #: _____

☐ Male ☐ Female Hobbies: _____

Home Address: _____ Home Phone #: _____

City: _____ State: _____ Zip: _____

Father/Guardian information

Name: _____ Birth Date: _____

Social Security #: _____ Marital Status: _____

Address (If same as Patient Please Check) ☐ _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Occupation: _____

Mother/Guardian information

Name: _____ Birth Date: _____

Social Security #: _____ Marital Status: _____

Address (If same as Patient Please Check) ☐ _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Occupation: _____

Referral information

Whom may we thank for referring you to our office?

☐ Another patient/Friend ☐ Another Dental Office ☐ Yellow Pages ☐ Online

**Please list either the persons name, insurance, other office referring you to our office:

_____

Dental Insurance Information

Policy Holders Name: _____ Birth Date: _____

Social Security #: _____ Employer: _____

Insurance Name: _____ Id #: _____

Insurance Address: _____

Insurance #: _____ Group #: _____

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and Fluoride, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Responsible Party: _____ Date: _____