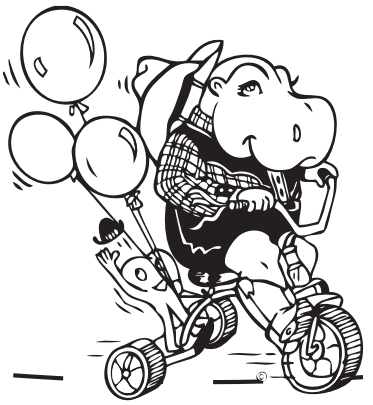
Alexandria pediatric Dentistry



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PATIENT ACQUAINTANCE INFORMATION

Date: _____

Child's Name: _____ DOB: _____
Child's Pediatrician: _____ Child's School: _____
Primary Language: _____

Sibling(s) Name: _____ DOB: _____
_____ DOB: _____
_____ DOB: _____

Mother's Information: ( ) Mother ( ) Stepmother ( ) Legal Guardian
Name: _____ DOB: _____
Address: _____
City/State/Zip: _____
Employer: _____ Position: _____
Home phone: _____ Social Security #: _____
Work phone: _____ DL#: _____
Cell Phone: _____ Email Address: _____
Primary Language: _____

Father's Information: ( ) Father ( ) Stepfather ( ) Legal Guardian
Name: _____ DOB: _____
Address: _____
City/State/Zip: _____
Employer: _____ Position: _____
Home phone: _____ Social Security #: _____
Work phone: _____ DL#: _____
Cell Phone: _____ Email Address: _____
Primary Language: _____

Child lives with ( ) Mother ( ) Father ( ) other _____

Parent's Dentist: _____ Whom may we thank for referring you? _____

Do you have dental insurance? Yes _____ No _____
Insurance Company: _____ Phone: _____
Employer: _____ Member ID#: _____ Group#: _____
Benefit Coverage Period: _____
Employee/Subscriber Name: _____ DOB: _____ SS#: _____
Is this child covered by Medicaid? Yes __ No __
Does this child have secondary dental insurance? Yes __ No __
Who is financially responsible for this account? Name _____ relationship_____