alexandria pediatric dentistry
anna brasher moreau, d.d.s., m.s.
board certified pediatric dentist

patient acquaintance information

Date: _____

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

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: _____

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: _____

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_____

www.bippothehippo.com • tel (318) 445-5471 • fax (318) 445-5901
1400 metro drive, suite a • alexandria, louisiana 71301