Churchwell Pediatric Dentistry PLC

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THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETEING IT IN FULL.

Patient's Name_____ Nickname _____
Sex _____ Race _____ Weight _____ Age _____ Date of Birth _____
Patient's Address _____
STREET CITY STATE ZIP
Home Phone _____ Social Security No. _____
Patient's School _____
Best Phone Number to Confirm/Text Appointments _____

Father's Name _____ Date of Birth _____
Dad's Address _____
STREET CITY STATE ZIP
Employer _____ Social Security No. _____
Home: _____ Work: _____ Cell: _____
Email Address _____

Mother's Name _____ Date of Birth _____
Mom's Address _____
STREET CITY STATE ZIP
Employer _____ Social Security No. _____
Home: _____ Work: _____ Cell: _____
Email Address _____

With whom does patient live? _____
Other children in family (names & ages) _____
Family Dentist _____
Dental Insurance Yes? ____ No? ____ Company _____
Policy No _____ Group No _____
Whom may we thank for referring you to our office? _____
Address, if known _____
STREET CITY STATE ZIP

How did you hear about out office? (Please check one)
Doctor ☐ Dentist ☐ Patient ☐ Parent ☐ School/Daycare ☐ Internet ☐

Insurance Co ☐

Signed: _____ Date: _____ Relationship: _____