



PATIENT INFORMATION

NAME _____ **GENDER:** MALE FEMALE
Last First Middle

NAME YOUR CHILD PREFERS TO BE CALLED: _____

BIRTHDAY ____/____/____ **AGE** ____ **WEIGHT** _____ **SOCIAL SECURITY NUMBER** ____/____/____

Have we seen another child in your family? Y N If yes, please list/Dr. seen? _____

Which Dentist is your child's appointment with today? Dr. Harris Dr. Meredith Not Sure

Who is your dentist? _____ Do not currently see a dentist Would like a recommendation

How did you hear about our office? (please mark all that apply and specify whom if applicable)

Phonebook Social Media (Facebook, Instagram, etc.) Internet (Google, Yahoo, etc) Print Ad TV/Radio

Friend/Relative _____ Physician/Dentist _____ Other _____

Who has legal guardianship of child:

_____	_____
Name/ Relationship	Name/ Relationship

Child currently lives with:

_____	_____
Name/ Relationship	Name/ Relationship

We would like to know a little about your child and what he/she likes: Pet's name: _____

Favorite color: _____ Hobbies: _____

EMERGENCY INFORMATION

Name of nearest relative/friend not living with you _____ **Relationship** _____

Complete Address _____ **Phone** _____

HAS YOUR CHILD:

Yes No Ever visited the dentist before?

Name of Dentist _____ City/State _____

Date of last visit? _____ Were x-rays taken? _____

Yes No Ever had an unfavorable dental/medical visit? If yes, please explain: _____

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