Pediatric DENTAL SPECIALISTS, P.A.
CREATING SOMETHING TO SMILE ABOUT!

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? _____

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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