JUST 4 KIDS

Pediatric Dentistry & Sedation

Patient information

Patient name:____Date of Birth:_____________________

Street Adress:____Apartment #________________

City/State/Zip Code____

Social security #__________________________

Responsible Party information

Name:____Date of Birth________________________

Married ▫ Single Other

Social Security #:______________________________

Phone: (Home)________________________(Cell)________________________Work______________________

Street Adress:____Apartment #____________________________

City/State/Zip Code____

Email address:____

Insurance information

Name of insured:____Date of Birth:_______________________

Relationship to patient:____________________Social Security#:___________________________________

Name of employer:___________________________Insurance Company:_____________________________

Group #:_____________________ID#_____________________________

Secondary Insurance information

Name of insured:____Date of Birth:_______________________

Relationship to patient:____________________Social Security#:___________________________________

Name of employer:___________________________Insurance Company:_____________________________

Group #:_____________________ID#_____________________________

Emergency Contact Information:

Name:____Phone:______________________________

Relationship to Patient:_____________________________

How did you hear about us?____

By signing below I acknowledge all the information on this form is correct.

Parent Signature:____