Pediatric Dentistry

FAMILY INFORMATION SHEET

Date _____ Patient(s) names(s) _____
Other children under age 18 _____

GUARDIAN INFORMATION

Father's Name_____
E-mail Address _____
Birth date _____/_____/_____
Address_____
PO BOX _____
City _____State_____Zip_____
Phone #_____
Cell Phone # _____
Social Security # _____
Employer _____
Employer's Phone # _____
Employer's Address _____

Mother's Name_____
E-mail Address: _____
Birth date_____/_____/_____
Address _____
PO BOX _____
City_____State_____Zip_____
Phone #_____
Cell Phone #_____
Social Security #_____
Employer _____
Employer's Phone #_____
Employer's Address _____

Dental Insurance Company (If applicable)
Policyholder _____
ID # _____

Dental Insurance Company (If applicable)
Policyholder_____
ID # _____

Person to contact in case of emergency _____
Address _____Phone #_____Relationship_____

How did you hear about us? (Please circle one or indicate name)

Dex Phonebook Bridgerland Phonebook Cache Valley Directory Internet Search/Google
Our Building Sign Our Website Facebook

Friend_____ Family_____

Dentist/Doctor_____ Other_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

The **parent or guardian who accompanies the child** is responsible for payment at the time of service, unless prior arrangements have been made.

Name of responsible party:_____Relationship:_____
In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services.

Signed: _____ Date: _____