CHILDREN’S ACQUAINTANCE FORM & HEALTH HISTORY

Child’s Name ____ Date ____________
Birth Date ____________________________ Home Phone ________________________
Address ____
Street City State Zip

Father’s Name ____
Birth Date ____________________________ Social Security # ______________________
Address ____
Street City State Zip

Home Phone _________________________ Work Phone __________________________
Employer ____

Mother’s Name____
Birth Date ____________________________ Social Security # ______________________
Address ____
Street City State Zip

Home Phone _________________________ Work Phone __________________________
Employer ____
Cell Phone ______________________________ Fax ____________________________
E-Mail ____

Person Responsible for Account? ____

Whom may we thank for this referral? ____

Dental Insurance: Yes_____ No_____ Insurance Co. _____________________________

Employee _______________________ Group # ____________ Phone _______________

Address ____

What prompted you to seek dental care at this time? ______________________________

Name of previous dentist ____

May we request your previous dental records to facilitate proper treatment in our office?

Yes _______ No _______