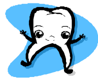
SWEET HOME
PEDIATRIC DENTISTRY



PATIENT INFORMATION

Has any member of your family been a patient of our office? Yes / No Name of Siblings:___________________

Date:_____________________ ___________________

Patient Name:____ Patient **Social Security** #:_________________________

Address:____Tel (C):_____________________________

City:_________________________________ State: ________ Zip: _____________ Tel (H):_______________________

Birthday: ______/______/________/ Age:________ Sex: Male/Female: _____________

Parent Employed By:____ Parent Occupation:________________________

Business Address:_____________________________________E-Mail:____

City:___________________________________ State: __________ Zip: _____________ Tel:__________________________

Who is responsible for this account?_______________________________ Relationship to Patient: _____________________

Who should we contact in an emergency?____________________________________ Phone:__________________________

DENTAL INSURANCE INFORMATION

Dental Insurance Primary Carrier

Insured's Name: Social Security #:

Insurance Company:

Address:

Group Number: ID Number: Birthday:

Insured's Employer:

Dental Insurance Secondary Carrier

Insured's Name: Social Security #:

Insurance Company:

Address:

Group Number: ID Number: Birthday:

Insured's Employer:

What problems would you like to discuss with the doctor and how may we help you?________________________________

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How did you hear of our office?____

CHARGES AND PAYMENTS: Charges will be explained and agreed prior to dental treatment. Payment is payable **at the time services** are rendered. There is a **charge for broken appointments**. Failure to keep a reservation and/or failure to give the office more than a 24 hour working day notice of cancellation will constitute a broken appointment.

Thank you for your cooperation and for selecting our dental office. We will do our best to make your visits as caring as possible.