

Child Questionnaire

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we must know as much about the individual as we do about his teeth. No two people are the same; no two mouths are alike. All information, of course, will be held in strict confidence.

By working together, we can strive to keep your natural teeth and thus improve your enjoyment of food, your appearance, your comfort and your health for the rest of your life.

Date _____

Patient's Name _____ Date of Birth _____

Name (Mother or Father) _____

Home Address _____

City _____ State _____ ZIP _____

Home Phone _____ Are there any Medical Alerts? _____

Is patient covered under a Dental Insurance Plan? _____ If so,

Carrier Name & Address _____

Phone # _____

For what company does Father work? _____

Address _____

Business Phone _____ Ext. _____

Occupation of your Mother _____

For what company does she work? _____

Address _____

Phone _____ Ext. _____

Insurance Carrier Name & Address _____

Phone # _____ Number of Children in Family? _____

Ages _____ Notes _____

Father's Social Security No. _____

Mother's Social Security No. _____

Name & address of person responsible for payment _____