



Parent/Legal Guardian Contact Information

Primary Insurance Carrier Name: _____

Primary Insurance Carrier Date of Birth: _____

Primary Insurance Carrier Social Security #: _____

Primary Insurance Carrier Relationship to Patient: _____

Is the Primary Insurance Carrier a Parent or Legal Guardian of the patient?

Yes _____ No _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Married _____ Divorced: _____ Single _____ Partnered _____

If Divorced who has legal custody of child(ren)'s Medical/Dental Decisions: _____

Spouse/Significant Others Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employer: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone #: _____

Please specify which phone number is best to confirm your child's appointment:

Phone Number: _____

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

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Patient Name: _____ Patient DOB: _____

How did you hear about us? _____

~OFFICE USE ONLY~

Insurance Information

Primary Insurance Provider: _____

Insurance Subscriber ID: _____ Insurance Group #: _____