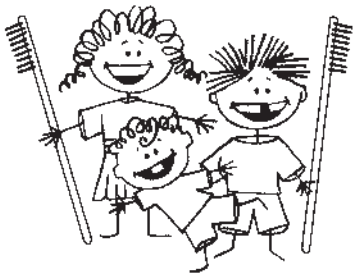

SOUTH DAVIS PEDIATRIC DENTISTRY

CHILD'S NAME: First_____ Last_____ Male Female
Birthdate: _____ Age: _____ School:_____
Home Address: _____
City, State, Zip Code: _____
Child lives with: (circle one) Father Mother Both Other _____
Marital status of parents: (circle one) Married Single Divorced Separated Widowed

FATHER: _____ Home Phone: _____ Cell Phone: _____
Social Security Number: _____ Birthdate: _____
Father's Employer: _____ Work Phone: _____
Home Address (if different than child's) _____
E-mail Address: _____

MOTHER: _____ Home Phone: _____ Cell Phone:_____
Social Security Number: _____ Birthdate: _____
Mother's Employer: _____ Work Phone: _____
Home Address (if different than child's) _____
E-mail Address: _____

PAYMENT OPTIONS: Method of payment (please circle one)
Cash, Check or Credit Card at time of service Insurance and co-pay at time of service
Medicaid and co-pay if applicable

PRIMARY DENTAL INSURANCE:
Name: _____
Phone: _____ Policy#_____
Address: _____
_____
Insured Persons Name: _____

SECONDARY DENTAL INSURANCE:
Name: _____
Phone:_____ Policy#_____
Address: _____
_____
Insured Persons Name:_____

HEALTH (medical) INSURANCE INFO: Name _____
Address: _____ Phone: _____
Insured Persons Name:_____

REFERRAL INFORMATION:
Whom may we thank for referring you to our office?
Dental Office: (Doctor's Name) _____ Yellow Pages:_____
Another Patient: (name) _____ Friend: (name) _____
School: _____ Work: _____ Other: _____