



## REDWOOD 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: \_\_\_\_\_

Mothers'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: \_\_\_\_\_