

# thank you for selecting us.

Patient ID # \_\_\_\_\_

Today's Date \_\_\_\_\_

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

## Your Child

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Nickname \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Birthdate \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Child's Home Address \_\_\_\_\_

City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

SS#/SIN \_\_\_\_\_ DL # \_\_\_\_\_

Who is Responsible for Making Appointments? \_\_\_\_\_

**Parent or Guardian Information**     Mother     Stepmother     Guardian

Name \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

SS#/SIN \_\_\_\_\_ DL # \_\_\_\_\_

Marital Status     Single     Married     Separated     Divorced     Widowed

**Parent or Guardian Information**     Father     Stepfather     Guardian

Name \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

SS#/SIN \_\_\_\_\_ DL # \_\_\_\_\_

Marital Status     Single     Married     Separated     Divorced     Widowed

## Primary Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employee # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Deductible \_\_\_\_\_ Copay \_\_\_\_\_ Amount already used \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

## Additional Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employee # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Deductible \_\_\_\_\_ Copay \_\_\_\_\_ Amount already used \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please



