Bethlehem Town Family Dental

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Grade Level _____ Home Phone _____

Father's Name _____ Father's SS # _____

Father's Address & Phone (if different than child)_____

Father's Employer and Phone Number _____

Mother's Name _____ Mother's SS # _____

Mother's Address & Phone (if different than child) _____

Mother's Employer & Phone Number _____

Please list other family members we have seen: _____

Insurance Information

Insurance Company Name _____

Insurance Co. Phone # _____ Insurance Patient ID # _____

Insured Name _____ Relationship to Insured _____

Insured SS # _____ Group # _____

Insured Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Physician's Name _____ Name of Former Dentist _____

How did you hear about our office? _____

Whom may we thank for your referral? _____

Print Name of Parent / Guardian: _____

X_____ Date _____

Parent/Guardian Signature