Child Questionnaire

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we must know as much about the individual as we do about his teeth. No two people are the same; no two mouths are alike. All information, of course, will be held in strict confidence.

By working together, we can strive to keep your natural teeth and thus improve your enjoyment of food, your appearance, your comfort and your health for the rest of your life.

	Date		
Patient's Name	Date of Birth		
Name (Mother or Father)			
Home Address			
City	State	ZIP	
Home Phone	_ Are there any Medical Alerts?	·	
Is patient covered under a Dental Insur	rance Plan?	If	f so,
Carrier Name & Address			
	Phone #		
For what company does Father work?			
Address			
Business Phone		Ext	
Occupation of your Mother			
For what company does she work?			
Address			
Phone		Ext	
Insurance Carrier Name & Address	··		
Phone #	_ Number of Children in Family?		_
Ages	Notes		
Father's Social Security No.			
Mother's Social Security No			
Name & address of person responsible	e for payment		
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