

# Welcome

Patient ID # \_\_\_\_\_ Today's Date \_\_\_\_\_

*to our practice! 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 \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Email \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

## Who is responsible for making appointments?

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Best time to call \_\_\_\_\_  
Time \_\_\_\_\_ Days \_\_\_\_\_

### Mother Stepmother Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

### Father Stepfather Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

**Marital Status**  Single  Married  Divorced  
 Widowed  Separated

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 Widowed  Separated

## Primary Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
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 Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.  Cash  Personal Check  
 Credit Card  Visa  MC  I wish to discuss the office's payment policy.