THEODORE A. TANABE, D.D.S.

PATIENT INFORMATION RECORD - CHILDREN

Date:_____ Full Time College Student ☐ Yes ☐ No School attending _____

Patient Name:_____
First Middle Initial Last

Address:_____
Street Apt. # City State Zip

Phone: (____) _____Age:_____ Date of Birth: _____Sex:_____

Patient's Social Security Number:_____ Patient's Cell: (____)_____

Father's Name: _____Cell: (____)_____

Social Security Number: _____ Date of Birth:_____

Address (if different than patient's):_____

Phone: (____)_____

Employer: _____ Occupation: _____

Address : _____Phone: (____)_____

Mother's Name: _____Cell: (____)_____

Social Security Number: _____ Date of Birth:_____

Address (if different than patient's):_____

Phone: (____)_____

Employer: _____ Occupation: _____

Address : _____Phone: (____)_____

Dentist: _____ **Orthodontist:** _____

Referred by:_____

Physician:_____

Nearest Friend or Relative: _____Phone: (____)_____

INSURANCE INFORMATION

Primary Dental Insurance: _____ Group #:_____

Address:_____

Subscriber Name (insured):_____

Secondary Dental Insurance: _____ Group #:_____

Address:_____

Subscriber Name (insured):_____

Primary Medical Insurance:_____ Group #:_____

Address:_____

Subscriber Name (insured):_____

Secondary Medical Insurance: _____ Group #:_____

Address:_____

Subscriber Name (insured):_____