Kids Dental Barn

Patients Information

Name: _____Preferred Name: _____

Date of Birth: _____ Age: _____ Phone#_____

Please Circle: Male or Female Text Yes/ No: ____ Best number to text:_____

Address: _____ City: _____State:_____ Zip: _____

How did you hear about our office? ☺_____

Parent/Guardian Information

Mother **(Full Name)** _____Preferred Name: _____

Please Circle if you are the: Mother Step Mother Legal Guardian Other_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____Work: _____Cell:_____

SS#:_____ Date of Birth_____ Employer: _____

E-mail: _____

Parents Marital Status: (please circle one) Married Single Divorced Widowed

Father **(Full Name)** _____Preferred Name: _____

Please Circle if you are the: Father Step Father Legal Guardian Other_____

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Work Phone: _____ Cell: _____

SS#:_____ Date of Birth_____ Employer: _____

E-mail: _____

Primary Dental Insurance

Insurance Company: _____

Address: _____

Phone #: _____

Group #: _____

Subscribers Name: _____

Subscribers ID#: _____

Subscribers Date of Birth: _____

Employer: _____

Secondary Dental Insurance

Insurance Company: _____

Address: _____

Phone #: _____

Group #: _____

Subscribers Name: _____

Subscribers ID#: _____

Subscribers Date of Birth: _____

Employer: _____