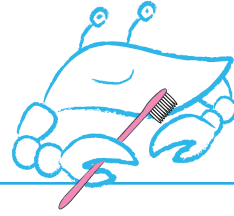


# NEW PATIENT FORM



KENT ISLAND  
PEDIATRIC  
DENTISTRY

Date: \_\_\_\_\_

Whom may we thank for referring you to: \_\_\_\_\_

## YOUR CHILD

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  Male  
last first mi  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Child's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Who is accompanying child today: \_\_\_\_\_ Relationship: \_\_\_\_\_

Names and ages of other children in family: \_\_\_\_\_

## RESPONSIBLE PARTY

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DL: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Home : ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Who is responsible for making appointments: \_\_\_\_\_

## PARENT or GUARDIAN INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DL: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Home : ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

## PARENT or GUARDIAN INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DL: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Home : ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home : ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

## PRIMARY INSURANCE

Insured's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group No: \_\_\_\_\_ Employee No: \_\_\_\_\_

Ins Co Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## ADDITIONAL INSURANCE

Insured's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group No: \_\_\_\_\_ Employee No: \_\_\_\_\_

Ins Co Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

