



Westerville

PEDIATRIC DENTAL

Practice Limited to Pediatric & Adolescent Care

Child Information

Name: _____ Relationship: _____
 Preferred Name: _____ Male Female Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Referred By: _____
 Physician's Name: _____ Physician's Phone: () _____

Children in Household

Name _____ Relationship _____ Birth Date _____ Age _____
 Name _____ Relationship _____ Birth Date _____ Age _____
 Name _____ Relationship _____ Birth Date _____ Age _____
 Name _____ Relationship _____ Birth Date _____ Age _____
 Name _____ Relationship _____ Birth Date _____ Age _____

Responsible Party Information

Mother Name: _____ Single Married Divorced Other
 Home #: () _____ Cell #: () _____
 Address (if different): _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ **Date of Birth:** _____
 Employer: _____ Work Phone: () _____
 Occupation: _____ **Email:** _____

Father Name: _____ Single Married Divorced Other
 Home #: () _____ Cell #: () _____
 Address (if different): _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ **Date of Birth:** _____
 Employer: _____ Work Phone: () _____
 Occupation: _____ **Email:** _____

Emergency Information

Please list a local contact in an emergency (other than listed above).
 Name: _____ Relation: _____
 Home Phone: () _____ Mobile: () _____

Responsible Party Dental Insurance Information

Primary Subscriber Name: _____ Primary Responsible Party Employer: _____
 Dental Insurance Company Name: _____
 Phone: () _____ Policy Number: _____ Group Number: _____
 Secondary Subscriber Name: _____ Secondary Responsible Party Employer: _____
 Dental Insurance Company Name: _____
 Phone: () _____ Policy Number: _____ Group Number: _____

As the responsible party, I hereby agree to provide payment for all services, regardless of insurance coverage.

Signature of Responsible Party: _____ Date: _____