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## First Visit Questionnaire

### 1. Tell us about your child

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Male  Female Child's Age: \_\_\_ Child's Birthdate: \_\_\_/\_\_\_/\_\_\_  
 S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Home Phone Number: \_\_\_\_\_  
 Home Address: \_\_\_\_\_

### 2. Who is accompanying your child today?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Do you have legal custody of this child?  Yes  No  
 Who may we thank for referring you? \_\_\_\_\_  
 Previous Dentist: \_\_\_\_\_ Present Dentist: \_\_\_\_\_  
 Last visit date: \_\_\_\_\_  
 Other family members seen by us: \_\_\_\_\_  
 Parent's marital status (check one):  
 Single  Widowed  Separated  Married  Divorced

### 3. Mother's information: (circle if: step mother or guardian)

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Work #: \_\_\_\_\_ Home#: \_\_\_\_\_  
 S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Father's Information: (circle if: step father or guardian)

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Work #: \_\_\_\_\_ Home#: \_\_\_\_\_  
 S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### 4. Person responsible for account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Work #: \_\_\_\_\_ Home#: \_\_\_\_\_  
 Employer: \_\_\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**5. Primary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_ Insurance Co. Phone #: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Parent: \_\_\_\_\_

Insured's S.S. #: \_\_\_\_\_ Insured's I.D. #: \_\_\_\_\_

Insured's Birthday: \_\_\_ / \_\_\_ / \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Orthodontic Coverage (check one):  Yes  No

**6. Secondary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_ Insurance Co. Phone #: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Parent: \_\_\_\_\_

Insured's S.S. #: \_\_\_\_\_ Insured's I.D. #: \_\_\_\_\_

Insured's Birthday: \_\_\_ / \_\_\_ / \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Orthodontic Coverage (check one):  Yes  No

**7. Relative we can call if needed**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work #: \_\_\_\_\_ Home#: \_\_\_\_\_

**I understand that the information that I have given is correct** to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need.

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

**OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_