

Tell us about yourself:

Patient's name:		First		N	Middle
Nickname:	Patient's Bir	thday:/_	/	Patient's	Age:
Male Female School:		-			
Patient's Home Address:		City:	S	tate:	_Zip:
Patient's Home Phone #: ()	SSN #:		Email Address:		
Who is accompanying the child today?					
Name:	Relation:	Do yo	ou have custody	of the child?	☐ Yes ☐ No
Whom may we thank for referring you?					
Other family members seen by us:					
Previous / Present Dentist:			Last	visit date: _	
Parent Information:					
Parent Status: ☐ Single ☐ Married	☐ Partnered	☐ Divorced	☐ Separated	□Wido	owed
Mother's Information: ☐ Legal Guardian					
Financially Responsible? ☐ Yes ☐ No	Responsible for	Making Appoint	ments? ☐ Yes ☐	□No	
Name:			Birthdate:	/	/
Email Address:				-	
Home #: () Cell # (_) E	mployer:	W	/ork #: ()	
SSN:	DL	#:			
Father's Information: ☐ Legal Guardian					
Financially Responsible? ☐ Yes ☐ No	Responsible for I	Making Appoint	ments? ☐ Yes ☐	□No	
Name:			Birthdate:	/	
Email Address:					
Home #: () Cell # (_) Eı	mployer:	W	ork #: ())
SSN:	DL	#:			
Emergency Contact:					
Name:			P	hone: ()	
Address:		City:	S	tate:	_ Zip:
Insurance Information:					
Insurance Company Name:	Subscrib	er ID #:	Secondar	y Ins.:	
General Health History:					
Child's Physician:	Phone #	: ()	Date	of Last Visit:	,
Is the child currently under the care of a ph	nysician? 🗌 Yes 🏻	□No			
Please describe the child's current physical	health: 🗆 Good	☐ Fair ☐ I	Poor		

Welcome to our practice! Our goal is to make your child's dentist visit as fun and as educational as possible. Our practice is based on preventative care. We strive to teach good oral hygiene that will enable your child to have a beautiful and healthy smile for a lifetime. Thank you for choosing us! – *Dr. Favalli & The Team*