Pediatric Form

Sunny Smiles Pediatric and Family Dentistry

We are pleased that you have chosen "Sunny Smiles" for your child's dental care. We believe in treating your child as our own.

Name of Child: ____

Child's Birthdate: _____/_____/_____ Child's Age: ___________

Prefers to be called: ________________ Gender/Sex: Male Female

Child's Home address: ____
Street
____
City State Zip

Child's Home Phone: ______________________________

How did you hear about our office? ______________________________

Mother/Guardian's Information

Name: ____
Birthdate: _____/_____/_____
Home Phone: _________________________ Cell Phone: ____________________
E-mail: ______________________________
Home Address: (Please list if other than child's)

____
Street
____
City State Zip

Employer: ____________________________________ SS#: _________________________

Father/Guardian's Information

Name: ____
Birthdate: _____/_____/_____
Home Phone: _________________________ Cell Phone: ____________________
E-mail: ______________________________
Home Address: (Please list if other than child's)

____
Street
____
City State Zip

Employer: ____________________________________ SS#: _________________________

Name of Dental Insurance Policy Holder: ____
Relationship to child: ____
Policy Holder's Birthdate: _____/_____/_____
Dental Insurance Provider: _________________________________
Member ID Number or SSN: ___________________________________
Group #: ____