Patient Information for a Minor Patient

Today's date: _____

Patient name (first, MI, last): _____

Patient's nickname: _____

Patient's primary residency: ☐ Both parents ☐ Mother ☐ Father ☐ Stepparent ☐ Shared custody ☐ Guardian

Address (street, city, state, ZIP): _____

Home phone: _____ Gender: ☐ Male ☐ Female

Date of birth: _____ Age: _____

School: _____ Hobbies/sports: _____

Names and ages of other children in your family: _____

Parent / Guardian Information

Name of responsible party (first, MI, last): _____

Date of birth: _____ Relationship to patient: _____

Address (if different from patient), (street, city, state, ZIP): _____

Home phone: _____ Work phone: _____

Mobile phone: _____ E-mail: _____

By providing your e-mail address you agree to receive (check one or both): ☐ Appointment reminders ☐ Practice newsletter

Employer: _____ Occupation: _____ Work phone: _____

Work address (street, city, state, ZIP): _____

Name of financially responsible party, (if different from above), (first, MI, last): _____

Is financially responsible party the same as legal guardian? ☐ Yes ☐ No

Date of birth: _____ Relationship to patient (mother, father or other): _____

Address (if different from patient), (street, city, state, ZIP): _____

Employer: _____ Occupation: _____ Work phone: _____

Work address (street, city, state, ZIP): _____

Dental Benefit Plan Information

Primary dental plan name: _____

Address (street, city, state, ZIP): _____

Name of insured: _____ Date of birth: _____

ID number: _____ Policy number: _____

Patient relationship to insured: _____

Secondary dental plan name: _____

Address (street, city, state, ZIP): _____

Name of insured: _____ Date of birth: _____

ID number: _____ Policy number: _____

Patient relationship to insured: _____

Medical Plan Information

Plan name: _____

Address (street, city, state, ZIP): _____

Name of insured: _____ Date of birth: _____

ID number: _____ Policy number: _____

Patient relationship to insured: _____