

Welcome to...



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOUR CHILD

Today's Date _____
Child's Name _____
Nickname: _____ Sex: _____
Child's Birthdate: _____ Age: _____
School: _____ Grade: _____
Child's Home Address: _____

CITY STATE ZIP CODE
Home Phone _____
Name/Age of Siblings: _____
Previous Dentist: _____
Last Visit Date: _____
Who may we thank for referring you? _____
EMERGENCY CONTACT (Nearest friend or relative not living with you):
Name: _____
WK# _____ HM# _____
Relationship: _____

MOTHER'S INFORMATION (Stepmother____ Guardian____)

Name: _____
Address: _____
WK# _____ HM# _____
Cell# _____ E-mail _____
Employer: _____
Occupation: _____
Birthdate _____ SS# _____

FATHER'S INFORMATION (Stepfather____ Guardian____)

Name: _____
Address: _____
WK# _____ HM# _____
Cell# _____ E-mail _____
Employer: _____
Occupation: _____
Birthdate _____ SS# _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relation: _____
Billing Address (if different from patient): _____

CITY STATE ZIP CODE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Phone #: _____
ID # _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____
Relationship to Patient: _____
Insured's Birthdate: _____ SS# _____
Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Phone #: _____
ID # _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____
Relationship to Patient: _____
Insured's Birthdate: _____ SS# _____
Insured's Employer: _____

I hereby authorize payment to KiDDS Dental Liberty Lake of insurance benefits otherwise payable to me. I authorize the doctors to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on the page is true and correct to the best of my knowledge.

Signature _____
Circle One: Parent Guardian

Date _____