



Welcome to Young Dentistry for Children!

Your Name _____

Today's Date _____

Patient Names

1st Child's Name _____

M ___ F ___ Birthdate _____

2nd Child's Name _____

M ___ F ___ Birthdate _____

3rd Child's Name _____

M ___ F ___ Birthdate _____

Who do the children live with?

Who may we thank for referring you to our practice?

Responsible Party

Name _____

Relationship to patient _____

Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____ Ext _____

Employer _____

Occupation _____

Social Security # _____

Mother Stepmother Guardian

Please fill out if not listed above as responsible party

Name _____

Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Employer _____

Occupation _____

Work Phone _____ Ext _____

SS# _____

Father Stepfather Guardian

Please fill out if not listed above as responsible party

Name _____

Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Employer _____

Occupation _____

Work Phone _____ Ext _____

SS# _____

Who is responsible for making appointments?

Name _____ Relationship _____

How may we contact you? Home Phone Work Phone Cell Phone