Child Information Sheet

Date: _____

Name: _____ Nickname: _____

D.O.B.: _____/_____/_____ Age: _____ School: _____ Grade: _____

Address _____

Street or P.O. Box City State Zip

Home Phone: _____ Cell Phone: _____

Father's Name: _____ Mother's Name: _____

Father's Home Phone: _____ Mother's Home Phone: _____

Father's Employer: _____ Mother's Employer: _____

Father's Business Phone: _____ Mother's Business Phone: _____

Address where statement should be sent if different than above:

_____

HOW DID YOU HEAR ABOUT US? _____

Insurance Information

If you have insurance that will assist you with a portion of your account, please complete the following:

Employee Name: _____ D.O.B.:____/____/____ SS#:_____-___-_____

Employer Name:_____ Insurance Company: _____

Insurance Company Mailing Address:_____

Group Number:_____ Is this insurance: ☐ Dental or ☐ Medical

Relationship of the patient to the insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Additional Coverage

Employee Name: _____ D.O.B.:____/____/____ SS#:_____-___-_____

Employer Name:_____ Insurance Company: _____

Insurance Company Mailing Address:_____

Group Number:_____ Is this insurance: ☐ Dental or ☐ Medical

Relationship of the patient to the insured: ☐ Self ☐ Spouse ☐ Child ☐ Other