

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?
IN CASE OF EMERGENCY CONTACT:
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

Date