

Three Oaks Dentistry

103 South Elm Street ◦ Three Oaks, Michigan 49128
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Child Patient Information

Child's Name: _____ Today's Date: _____

Preferred Name: _____ Male Female

Child's Date of Birth: _____ Child's Social Security Number: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Child's School: _____ Grade: _____

Referred by: _____

1st Guardian's Name: _____

Relationship to Patient: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Address: _____

Guardian's Employer: _____

Occupation: _____

(If responsible party) SS# _____

(If responsible party) DL# _____

2nd Guardian's Name: _____

Relationship to Patient: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Address: _____

Guardian's Employer: _____

Occupation: _____

(If responsible party) SS# _____

(If responsible party) DL# _____

Preference for Appointment Reminders: Phone Message Text Message

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____ Phone Number: _____

Primary Dental Insurance Information:

Name of Insured: _____

Insured: Male Female

Relationship to Patient: _____

Insured's Date of Birth: _____

Insured's Social Security #: _____

Insured Employer: _____

Insurance Company Name: _____

Group #: _____

Employee/Cert. #: _____

Secondary Dental Insurance Information:

Name of Insured: _____

Insured: Male Female

Relationship to Patient: _____

Insured's Date of Birth: _____

Insured's Social Security #: _____

Insured Employer: _____

Insurance Company Name: _____

Group #: _____

Employee/Cert. #: _____