Child Information Form

Patient's Name _____

Male ( ) Female ( ) Birthdate _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

If Student, List Name, City & State of School:

_____

If College: Full Time ( ) Part Time ( )

I hereby authorize any dental work or x-rays for this child from this date forward.

Signature _____ Date _____
Relationship to Child _____

118 WEST K ST.
BENICIA, CA 94510

Account

Mother: Name _____

Occupation _____

Employer _____

Business Phone _____

Business Address _____

City _____ State _____ Zip _____

Birthdate _____ SS# _____

Driver's License # _____State _____

Father: Name _____

Occupation _____

Employer _____

Business Phone _____

Business Address _____

City _____ State _____ Zip _____

Birthdate _____ SS# _____

Driver's License # _____ State ____

Insurance

Mother:
Carrier's Name _____

Group # _____ Local # _____

Date hired by Employer _____

Insurance Effective Date _____

Family Coverage? Yes ( ) No ( )

Father:
Carrier's Name _____

Group # _____ Local # _____

Date hired by Employer _____

Insurance Effective Date _____

Family Coverage? Yes ( ) No ( )

I prefer to pay with:
Cash ( ) Check ( ) Credit Card ( )