



Upstate Pediatric Dentistry

New Patient Information

Welcome to our office! Thank you for filling out this form completely.

Today's Date _____

Patient's Name _____ Patient's Date of Birth _____ Sex M / F
Last First MI

Social Security Number _____ Name Patient Prefers _____

Patient's Home Address _____
City _____ State _____ Zip _____ Phone # _____

School _____ Grade _____

Names and ages of siblings in family _____

Do parents live together? ___yes ___no If not, with whom does the child reside? _____

Patient or Guardian Information _____ **Mother** _____ **Stepmother** _____ **Guardian**

Name _____ DOB _____ Occupation _____
Last First MI

Employer _____ Work Phone # _____

SS# _____ Home # _____ Cell # _____

Marital Status _____ E-Mail address _____

Patient or Guardian Information _____ **Father** _____ **Stepfather** _____ **Guardian**

Name _____ DOB _____ Occupation _____
Last First MI

Employer _____ Work Phone # _____

SS# _____ Home # _____ Cell # _____

Marital Status _____ E-Mail address _____

Person responsible for payment of account _____ Driver's license # _____

How did you find out about our office? _____

Method of Payment

___Check or cash at time of treatment ___Debit Card ___Visa ___Master Card ___Discover ___Amex
___Insurance – plus co-payment at time of treatment
___South Carolina Medicaid # _____

Dental Insurance

Insured's Name _____ Relationship _____ Date of Birth _____

SS# _____ Employer _____

Insurance Company Name/Address _____

Group # _____ Policy # _____

Insurance Company Phone # _____

Signature of Legal Consent

Date