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 Birthdate: _____ Sex: M / F
(Last) (First) (MI)
Preferred Name: _____
Patient's Home Address: _____
City: _____ State: _____ Zip: _____ Phone # _____
School: _____ Grade: _____
Names and ages of siblings in family _____
How did you find out about our office? _____

Parent or Guardian Information _____ Mother _____Father _____Guardian
Name: _____ Birthdate: _____ SS#_____
(Last) (First) (MI)
Marital Status: _____
Cell # _____ E-Mail address: _____
Employer: _____ Occupation: _____

Parent or Guardian Information _____ Mother _____Father _____Guardian
Name: _____ Birthdate: _____ SS#_____
(Last) (First) (MI)
Marital Status: _____
Cell # _____ E-Mail address: _____
Employer: _____ Occupation: _____

Do parents live together? ____ Yes ____ No |If not, with whom does the child reside_____

Person responsible for payment account:
Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____

Dental Insurance Information:

☐ South Carolina Medicaid # _____

☐ Private Insurance Company Name: _____
Subscriber's Name: _____ Birthdate: _____ SS#_____
Subscriber's relationship to child: _____
Employer: _____
Policy #: _____ Group # _____

_____ _____
Signature of Legal Guardian **Date**