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? _____

Parent or Guardian Information _____ Mother _____ Father _____Guardian

Name _____ DOB _____ Occupation_____

Last First MI

Employer_____ Work Phone # _____

SS#_____ Home # _____ Cell # _____

Marital Status _____ E-Mail address _____

Parent or Guardian Information _____Mother _____Father _____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