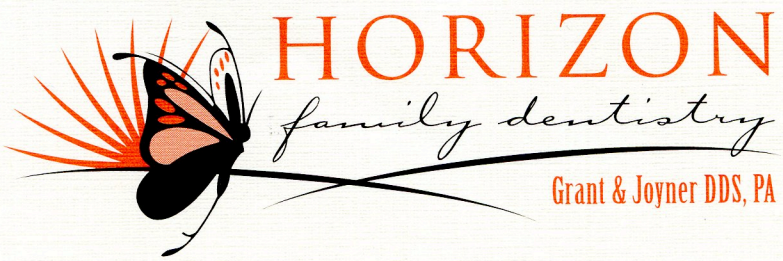

Child Patient Information Sheet

Patient Information
Child's Full Name _____
Name Called By _____ Age _____
Birthday _____ / _____ / _____ Sex: M____ F_____
Child's Home Address
_____
City _____ State _____ Zip Code _____
Home Phone ( ) _____
Child's Physician _____
Phone ( ) _____
Address _____
What is your Child's Current Weight? _____

Parent/Guardian Information
Parent/Guardian Name _____
Relationship to Patient: _____
Social Security # _____-_____-_____
Date of Birth: _____
Employer _____
Work/Mobile Phone (_) _____
Email Address_____
How did you find out about our office?
_____
Emergency Contact/Friend or Relative Not Living with You
Name _____
Phone ( ) _____
Address _____
Zip Code _____
Insurance Information: Insured's Name _____
Relationship to Patient _____
Insured's Date of Birth _____
Insured's Employer _____
Name of Insurance Company _____
Group Number _____

I have received the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan. To the extent permitted by law, I authorize release of any information relating to claims filed. I herby authorize payment of dental benefit directly to Grant and Joyner, DDS PA

_____ _____
Signature of Insured Date

6250 Rogers Road • Rolesville, NC 27571 • ph (919) 562-1520 • Fax (919) 562-3296