Shaughnessy Dental Kids

TELL US ABOUT YOUR CHILD

Patient's Name:_____
Date of Birth:_____Age:_____
Care Card #_____
Home Address:_____
_____
_____
Home Phone:_____
Nickname:_____M___F_____
School:_____Grade:_____
Interests:_____
_____
Pets:_____

FATHER'S INFORMATION

☐ Guardian ☐ Step

Name:_____
DOB:_____SIN:_____
Employer:_____
Home#:_____Work#:_____

MOTHER'S INFORMATION

☐ Guardian ☐ Step

Name:_____
DOB:_____SIN:_____
Employer:_____
Home#:_____Work#:_____

Who is accompanying the child today?

Name:_____
Relation:_____
Do you have legal custody of this child? Yes ☐ No ☐

In case of emergency, please call:

Name:_____
Phone#_____
Other family members seen by us:_____
_____
Name and Phone # of nearest relative not living with you:_____
_____
_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____
Relation:_____
Mailing Address:_____
_____
_____
Home#:_____Work#:_____

Who may we thank for referring you?

_____Patient _____Doctor_____Other
Name:_____
Phone#:_____

INSURANCE INFORMATION

Insured's Name:_____
Insured's Birthday:_____
Relationship to Patient:_____
Employer:_____
Work Phone #:_____Ext:_____
1.) Insurance Co. name:_____
Insurance group#/policy:_____
Insurance ID /certificate:_____
***Complete next section if dual insurance coverage applies**
2.) Insured's Name:_____
Insured's Birthday:_____
Employer:_____
Work Phone#: _____Ext:_____
Insurance Co. name:_____
Insurance group#/policy:_____
Insurance ID/certificate:_____