# PATIENT INFORMATION FORM

Please complete all the fields below.

HOPSCOTCH
CHILDREN'S GENERAL DENTISTRY

## Patient Info

Date: _____/_____/_____

Child's Full Name: _____ Nickname (If Any): _____
Birthdate: _____/_____/_____ Sex: M F (circle)
Address: _____
Reason For Visit: _____ Concerns: _____
Child's Interests and Hobbies: _____
Names and Ages of Siblings: _____
Is your child adopted? Y N Child's School: _____
Whom may we thank for referring you: _____

Mother's Full Name: _____SSN: _____
Birthdate: _____/_____/_____ Home Phone: _____ Cell Phone: _____
E-mail: _____ Home Address: _____
Employer: _____ Work Phone: _____
Work Address: _____

Father's Full Name: _____ SSN: _____
Birthdate: _____/_____/_____ Home Phone: _____ Cell Phone: _____
E-mail: _____ Home Address: _____
Employer: _____ Work Phone: _____
Work Address: _____

Child Lives With: _____

Parents are: Married Divorced Single Widowed

Person(s) Financially Responsible: _____ Emergency Contact: _____
Primary Insurance: _____ Phone Number: _____
Group Number: _____ Subscriber: _____ Birthdate: _____/_____/_____

Secondary Insurance: _____ Phone Number: _____
Group Number: _____ Subscriber: _____ Birthdate: _____/_____/_____

As a courtesy to our patients we will file your insurance claim with the insurance company(s) listed above for treatments your child receives. However, in the event your insurance company, for any reason, does not pay, the balance will be your responsibility, and will be directly billed to you. You understand this is a contract with Hopscotch Children's General Dentistry and that you are responsible for all charges.

Signature of Responsible Party: _____

Relationship to child: _____ Date:_____/_____/_____