Phelan ORTHODONTICS

James T. Phelan, DDS, MSD ☘ R. Thomas Phelan, DDS, MS

Specialists in Child & Adult Orthodontics

Date:

CHILD INFORMATION FORM

Patient Name_____ ☐ Male ☐ Female

Social Security #_____Birth Date_____Age_____

Home Address _____

City_____State_____ Zip_____

Primary Phone #_____ ☐ home ☐ cell Ok to leave Message? ☐ Y ☐ N

Email _____

School _____

List any sports or extracurricular activities _____

Siblings (names and ages) _____

Parent's Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Mother ☐ Step-Mother ☐ Guardian ☐ Other Name_____

Social Security #_____Birth Date_____

Address (if different from child's) _____

City_____State_____ Zip_____

Phone #_____ ☐ home ☐ cell Secondary Phone #_____ ☐ home ☐ cell

Employer's Name_____Occupation_____

☐ Father ☐ Step-Father ☐ Guardian ☐ Other Name_____

Social Security #_____Birth Date_____

Address (if different from child's) _____

City_____State_____ Zip_____

Phone #_____ ☐ home ☐ cell Secondary Phone #_____ ☐ home ☐ cell

Employer's Name_____Occupation_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name (outside of household)_____

Phone #_____Relation to child_____

Address _____

City_____State_____ Zip_____

Person(s) OK to release appointment or medically related information to concerning the child.

Name_____ Relation to child_____

PRIMARY DENTAL INSURANCE

Policy Holder's Name _____

Policy Holder's Birth Date_____Policy Holder's SSN _____

Employer_____ Relation to Patient_____

Insurance Company Name_____

Insurance Phone Number _____

Group Number _____

Policy Number_____

SECONDARY DENTAL INSURANCE

Policy Holder's Name _____

Policy Holder's Birth Date_____Policy Holder's SSN _____

Employer_____ Relation to Patient_____

Insurance Company Name_____

Insurance Phone Number _____

Group Number _____

Policy Number_____