LITTLE PENGUIN
PEDIATRIC DENTISTRY

Please fill out the form completely and accurately

PATIENT INFORMATION

First Name _____ Last Name _____

Nickname _____

Birthdate _____ Age _____ Sex M F

How did you hear about us?

(please circle one)

- Friend/Family
- Online
- Dentist Referral
- Insurance
- Other _____

PARENT/LEGAL GUARDIAN INFORMATION

First Name _____ Last Name _____ Birthdate _____

Relationship to Patient _____

Cell # _____ Home # _____ Email Address _____

Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

First Name _____ Last Name _____

Relationship to Patient _____ Phone # _____

INSURANCE INFORMATION

Do you have dental insurance? Y N

Insurance Company _____ Employer (AT&T, Kroger, etc.) _____

Name of Subscriber _____ Birthdate of Subscriber _____

Group # _____ Subscriber ID # _____

Insurance Phone # _____