Muir Station Smiles
CHILDREN'S DENTISTRY & ORTHODONTICS

# Welcome!

**QDW#:**_____

## Patient Information

Patient Name: LAST: _____ FIRST: _____M.I. _____ School:_____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female Social Security Number: _____

Last Dental Visit: _____/_____/_____ Reason For Visit:_____ Last X-rays Taken: _____/_____/_____

Last Dentist's Name: _____ City: _____ Phone (____) _____-_____

**Reason for today's visit/chief dental complaint:** _____

## Responsible Party Information

Name: LAST: _____ FIRST: _____ _ M.I.: ____ Relationship: _____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female Social Security Number: _____

Address Street: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Home Phone No.: (_____) _____ Mom's Cell: (_____) _____ Dad's Cell (_____) _____

Mom's Work No.: (_____) _____ Dad's Work No.: (_____) _____ E-mail: _____

Emergency contact other than family member: Name_____ Phone: (_____) _____

**Who may we thank for referring you to our office:** ☐ Internet ☐ Flier ☐ Passing By ☐ Mailer

☐ Patient: _____ ☐ Doctor: _____ ☐ Other: _____

## Please List All Members Of Your Immediate Family

| Family Member's Full Name | Now A Patient In This Office? | | Date of Birth | Relationship to Patient |
|---|---|---|---|---|
| 1. | ☐ Yes | ☐ No | | |
| 2. | ☐ Yes | ☐ No | | |
| 3. | ☐ Yes | ☐ No | | |
| 4. | ☐ Yes | ☐ No | | |

## Primary Dental Insurance Information

Insured's Name: _____

Insured's Date of Birth: _____/_____/_____

Insured's Social Security Number: _____

Insured's Employer:_____

Insured's Employer Phone No.: (_____) _____

Insurance Company Name: _____

Insurance Company Phone No: (_____) _____

Insurance Group No.: _____ Local: _____

## Secondary Dental Insurance Information

Insured's Name: _____

Insured's Date of Birth: _____/_____/_____

Insured's Social Security Number: _____

Insured's Employer: _____

Insured's Employer Phone No.: (_____) _____

Insurance Company Name: _____

Insurance Company Phone No: (_____) _____

Insurance Group No.: _____ Local: _____

Our office is collecting ethnic and racial information in order to develop systems and staff to provide the best quality of care to all of our patients. To do this we ask that you make the most appropriate selection regarding the race and ethnicity from the choices listed below. This information is voluntary and confidential.

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black ☐ Native American/Eskimo/Aleut ☐ Asian/Pacific Islander ☐ Other: _____ ☐ Unknown

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all charges regardless of insurance coverage. I hereby authorize the Dental Office to administer such medications including the use of local anesthetic and to perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are true and correct to the best of my knowledge. I hereby authorize the Dental Office to release my dental/medical information and other information about my dental treatment to third party payors and other health professionals.

Signature: _____ Driver's Lic #: _____ State: _____ Date: _____/_____/_____
(If a minor, parent or legal guardian)