

Patient Information

Patient Name: _____ Preferred Name: _____
 Male Female Date of Birth: ___/___/_____

Parent/Guardian Information

Father's Name		Mother's Name	
Social Security: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Social Security: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Home Address:		Home Address: <input type="checkbox"/> Same as Father's	
City:	Zip:	City:	Zip:
Primary Phone:		Primary Phone:	
Secondary Phone:		Secondary Phone:	
Employer:		Employer:	
Occupation:		Occupation:	
Dental Insurance: YES NO		Dental Insurance: YES NO	
E-mail: _____			

E-mail to send notices, reminders, and news - By mid-2014, all communication will be sent via e-mail. Please print clearly.

May we thank someone for telling you about Alpharetta Children's Dentistry & Orthodontics?

Friend: _____

Pediatrician: _____

School: _____

- Brochure
- Magazine/Newspaper
- Web Search (google, yahoo, etc.)
- Social media (facebook, twitter)
- New Beginnings Welcome Basket
- Cumming-Forsyth Chamber
- Website:
(alpharettachildrendentistry.com)
- Other: _____

First Appointment:

During most first appointments, we:

- Perform an examination of the teeth, the gums, and the surrounding tissue.
- Clean your child's teeth
- Apply a highly concentrated fluoride gel to the teeth (fluoride treatment).
- Take X-rays. X-rays are indicated during many, but not all first appointments.
- Teach and/or review proper oral hygiene methods if 6 or older when necessary.

Financial Agreement

I understand that I am financially responsible for any amounts due as a result of service, and acknowledge that I have read and agree to the financial policies on the reverse of this form.

Parent or Guardian Signature: _____ Date: ___/___/_____