



FAMILY INFORMATION SHEET

Date _____
 Patient(s) names(s) _____
 Other children under age 18 _____

GUARDIAN INFORMATION

Father's Name _____	Mother's Name _____
Birth date ____/____/____	Birth date ____/____/____
Address _____	Address _____
City _____ Zip _____	City _____ Zip _____
Phone # _____	Phone # _____
Social Security # _____	Social Security # _____
Employer _____	Employer _____
Employer's Phone # _____	Employer's Phone # _____
Employer's Address _____	Employer's Address _____
Dental Insurance Company (If applicable) Name _____	Dental Insurance Company (If applicable) Name _____
Group # _____	Group # _____
Person to contact in case of emergency _____	
Address _____	Phone # _____ Relationship _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

The parent or guardian who accompanies the child is responsible for payment at the time of service, unless prior arrangements have been made.

Name of responsible party: _____ Relationship: _____

In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services.

Signed: _____ Date: _____

INSURANCE INFORMATION (IF DIFFERENT FROM ABOVE)

Insurance Co. _____
 Address where claim should be sent _____
 Subscriber's Name _____ Birth date _____
 Social Security # _____ Employer _____
 Subscriber relationship to patient _____

SECONDARY INSURANCE

Insurance Co. _____
 Address where claim should be sent _____
 Subscriber's Name _____ Birth date _____
 Social Security # _____ Employer _____
 Subscriber relationship to patient _____