



FAMILY INFORMATION SHEET

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

GUARDIAN INFORMATION

Father's Name _____
E-Mail Address _____
Birth date ____/____/____
Address _____
PO BOX _____
City _____ State _____ Zip _____
Phone # _____
Social Security # _____
Employer _____
Employer's Phone # _____
Employer's Address _____

Mother's Name _____
E-mail Address: _____
Birth date ____/____/____
Address _____
PO BOX _____
City _____ State _____ Zip _____
Phone # _____
Social Security # _____
Employer _____
Employer's Phone # _____
Employer's Address _____

Dental Insurance Company (If applicable)
Name _____
Group # _____
Person to contact in case of emergency _____
Address _____ Phone # _____ Relationship _____

Dental Insurance Company (If applicable)
Name _____
Group # _____
Person to contact in case of emergency _____
Address _____ Phone # _____ Relationship _____

How did you hear about us? (Please circle one or indicate name)

Phone Book – Dex / Bridgerland / Local Pages / Cache Valley Directory
Our Building Sign Val-Pak Smile & Share Card
Internet Search Our Website Friend _____
Advertisement _____ Dentist/Doctor _____
Other _____

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: _____