



Patient Update

Date: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell/Work: _____

Insurance Information

Insurance Carrier: _____ Insurance Phone: _____

SS#: _____ Insurance ID #: _____

Policy Holder: _____ Date of Birth: _____

Employer: _____ Group #: _____

Medical Update

Has the patient had any changes in medical history Or new medication since last appointment?

If yes, please explain _____

Does your child(ren) have any dental problems that you'd like to discuss with the doctor?

If yes, please explain: _____

So that My Kidz Dentist may render treatment for your child/ (ren) it is required by law that we receive written consent from you the parent /guardian. It is also important that you understand that even if you have Dental/Medical insurance, you are responsible for any non-covered services of balances unpaid by your insurance company. In addition if your account is referred to collections you are responsible for all collection fees.

Parent/Guardian Signature _____ Date: _____