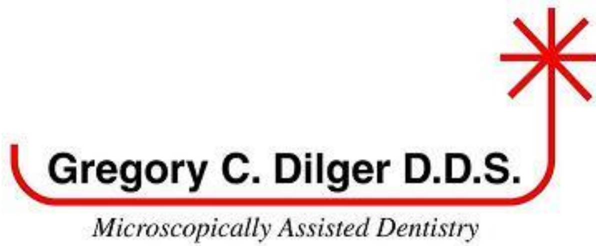

1353 Edgewater St. NW
Salem, Oregon 97304
(503) 378-0466

DATE:____________

WELCOME TO OUR PRACTICE

We are pleased and honored that you have chosen our office to help you with your child's Dental care.

We are trained to treat the area in the mouth, the gateway to the body. Our purpose is to assist you in achieving the level of good oral health that you desire for your child. The information asked for in this questionnaire will help us take better care of your child. Thank you for your help.

PERSONAL INFORMATION

CHILDS NAME	Male / Female	HOW DOES YOUR CHILD WISH TO BE ADDRESSED?

HOME ADDRESS	City	Zip	HOME PHONE	SS#

WHAT SCHOOL DOES YOUR CHILD ATTEND?	WHAT GRADE IS YOUR CHILD IN?	DATE OF BIRTH

WHO MAY WE THANK FOR REFERRING YOUR CHILD TO OUR OFFICE?

RESPONSIBLE PARTY	RELATIONSHIP TO THE PATIENT

HOME ADDRESS (IF DIFFERENT)	HOME PHONE	SS#	Male / Female

EMPLOYER

EMPLOYER ADDRESS	EMPLOYER PHONE	OCCUPATION

SPOUSE

EMPLOYER

EMPLOYER ADDRESS	EMPLOYER PHONE	OCCUPATION

INSURANCE INFORMATION

For your convenience, We will bill out and mail your insurance form for you. To avoid any misunderstanding, all professional services are charged directly to the patient and the patient and/or the responsible guardian are personally responsible for payment of fees. We do not render service on the basis that insurance companies will pay our fee. Each fee is individual for the patient being treated.

DENTAL INSURANCE CO.	ADDRESS	
NAME OF POLICY HOLDER	SS#	GROUP #
SECOND DENTAL INS. CO.	ADDRESS	
SECOND POLICY HOLDER	SS#	GROUP #