Confidential Patient Information

FRANZISKA K. DUTTON, D.D.S.

CHILD/MINOR

Today's date: _____

PERSONAL INFORMATION

Referred by: _____

Child/Minor Name: _____ DOB: _____ SS#: _____

Parent/Guardian Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

e-mail: _____ *Ck Preferred Contact No.* Home [ ] Work [ ] Cell [ ] e-mail [ ]

Sex: ❑M ❑F Sibling's Names and Ages: _____

Reason for your Initial Visit: _____

State any "Concern" or "Fear" of Dental Treatment?

_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS#: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

DENTAL INSURANCE INFORMATION

Primary Insurance: _____ **Subscriber's Name**: _____

Birth date: _____ SS/ID#: _____ Relationship: _____

Employer: _____ Group Plan: _____ Group#: _____

Insurance Co. Address: _____

Secondary Insurance: _____ **Subscriber's Name**: _____

Birth date: _____ SS/ID#: _____ Relationship: _____

Employer: _____ Group Plan: _____ Group#: _____

Insurance Co. Address: _____

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____