OAKVILLE DENTAL CARE

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1 ABOUT YOUR CHILD

Name _____
Preferred Name _____
Birthdate___/____/___ Age_____ SSN_____
Male ☐ Female ☐ School _____
Parent/Guardian's Name_____
Relationship _____
Address_____
City_____ State _____ ZIP _____
e-mail_____
home # _____ work #_____
mobile # _____
Whom may we thank for referring you? _____
Other family seen by us _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT
(if different from above)

Name _____ Relation _____
Home # _____ Work # _____
Mobile # _____ Birthdate _____
e-mail _____
Billing address _____
City _____ State _____ ZIP _____

Thank you for filling out this form completely.
It will allow us to serve you more effectively.
If you should have a question at any time, please ask us. We are happy to help!

3 INSURANCE

Provider Name _____
Provider Address _____
City_____ State _____ ZIP _____
Group # _____
Insureds Name _____ Relation _____
Insureds Birthdate _____ Insureds ID #_____
Insureds Employer _____ Insureds Ph# _____

SECONDARY INSURANCE

Provider Name _____
Provider Address _____
City_____ State _____ ZIP _____
Group # _____
Insureds Name _____ Relation _____
Insureds Birthdate _____ Insureds ID #_____
Insureds Employer _____ Insureds Ph# _____

4a MEDICAL HISTORY

Does your child have a personal physician? ☐ yes ☐ no
Physicians Name _____
Phone # _____ Last Visit Date _____
Is your child currently under the care of a physician?
☐ yes ☐ no
Please explain _____
_____

IN THE EVENT OF AN EMERGENCY, WHO SHALL WE CONTACT?

Name _____ Relation _____
Ph #1 _____ Alternate # _____