Hamilton Pediatric Dentistry, PC
3299 Clear Vista Ct. Suite B
Grand Rapids, MI 49525
Phone: 616-608-6826

Patient Information and Health History Form

Child's Full Name_____
Nickname:_____
Date of Birth:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____
Cell Phone: _____
SSN: _____
Age:_____
Gender:_____

Parent Information
Parent/Legal Guardian 1_____
Full Name:_____
Relationship to patient:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
SSN:_____
Date of Birth: _____
Home Phone:_____
Cell Phone:_____
Business Phone:_____
Email Address:_____
Dental Insurance:_____
Employer:_____
Group #:_____

Parent Information
Parent/Legal Guardian 2_____
Full Name:_____
Relationship to patient:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
SSN:_____
Date of Birth: _____
Home Phone:_____
Cell Phone:_____
Business Phone:_____
Email Address:_____
Dental Insurance:_____
Employer:_____
Group #:_____

WHOM MAY WE THANK FOR REFERING YOU?

Name:_____

EMERGENCY CONTACT

Name:_____
Relationship:_____
Home Phone:_____
Business Phone:_____
Cell Phone: _____

HEALTH CARE PROVIDER

Child's Physician/Pediatrician:_____
Office Phone:_____
Mailing Address:_____
City: _____
State: _____
Zip Code: _____

Printed Name:_____
Signature:_____
Date:_____