We would like to welcome you and your child to our office.
Our goal is to make every child's visit pleasant and educational.
We strive to teach good oral care that will enable your child to
have a beautiful smile that lasts a lifetime.

COASTLINE ORTHODONTICS

1. TELL US ABOUT YOUR CHILD

Today's Date: _____ Nickname: _____

Child's Name: _____ E-mail Address: _____ SSN: _____
LAST FIRST MI

Birthday: ___/___/___ Age: _____ ☐ Male ☐ Female School: _____ Grade: _____

Hobbies/Sports: _____ Child's Home#: _____

Child's Home Address: _____
APT/CONDO# CITY STATE ZIP

2. WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____ Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Please list any siblings and their ages: _____

General Dentist: _____ Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

3. PARENT'S INFORMATION

Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birthday: ___/___/___

Wk#: _____ Ext: _____ Hm#: _____

Employer: _____

Date of Employment: _____ Job Title: _____

SSN: _____ DL#: _____

Mother's Information: ☐ Step Father ☐ Guardian

Name: _____ Birthday: ___/___/___

Wk#: _____ Ext: _____ Hm#: _____

Employer: _____

Date of Employment: _____ Job Title: _____

SSN: _____ DL#: _____

4. PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

Employer: _____

Hm#: _____ DL#: _____

Previous Address: _____

Wk#: _____ Ext: _____ SSN: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name: _____ Wk#: _____ Ext: _____ Hm#: _____

5. ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group# (Plan, Local or Policy#): _____

Policy Owner's Name: _____ **Relation:** _____

Policy Owner's Birthdate: ___/___/___ **Insured's SSN:** _____

Policy Owner's Employer: _____

Employer's Address: _____

SECONDARY

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group# (Plan, Local or Policy#): _____

Policy Owner's Name: _____ **Relation:** _____

Policy Owner's Birthdate: ___/___/___ **Insured's SSN:** _____

Policy Owner's Employer: _____

Employer's Address: _____

PLEASE CONTINUE ON THE NEXT PAGE