

CHILD	ORTHODONTIC ACQUAINTANCE FORM	CHILD
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PATIENT INFORMATION		
Date / /	Last Name	First
Sex M F Age	Birthday / /	Email Addr.
Address and Apartment No.(No PO Box #)		
City, State and Zip Code		
Child's Home Tel and School	Child's School	
Name and relation of Emergency Contact Person		
Telephone of emergency contact person		
Referred By	Patient's Dentist	
Reason For Consultation		
Do you want/need the treatment finished by a certain date?		What date?

FINANCIALLY-RESPONSIBLE-PERSON'S INFORMATION		
Name	Birthday	Relation to Patient
Address and Apartment No (No PO Box #).		
City State and Zip Code		
Home Tel.	Email Addr.	
Occupation	Employer/Company	
Empl/Comp Address, City, State		Work Tel.
Social Security No.		
Insurance Carrier Name and ID No.		
Today, what method of payment are you using to pay for this consultation? 1. Cash 2. Credit Card 3. Debit Card 4. Healthplex 5. DC-37 6 UFT Insurance		
If treatment is started what method of payment will you use: 1. Cash 2. Credit/Debit Card...3. Insurance		
Select Preference: 1. Payment in full with discount 2. Initial payment and monthly installments		

PATIENT'S MOTHER INFORMATION		
Name	Occupation	
Home Addr and Tel.		
Comp/Empl, Name, Addr. And Tel.		
Soc. Sec No.		

PATIENT'S FATHER INFORMATION		
Name	Occupation	
Home Addr and Tel.		
Comp/Empl, Name, Addr. And Tel.		
Soc. Sec. No.		

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