PATIENT'S IDENTIFICATION FORM (CHILD)

Date : _____

Dentist's name : _____ Referred by : _____

Last name : _____

First name : _____

Date of Birth : _____Age :_____ Sex : ( ) M ( ) F
day/,month/year

Mother's name : _____

Mother's address : _____

City : _____Postal code : _____

Home phone number : ( ) _____-_____

Cell phone number : ( ) _____-_____

Work phone number : ( ) _____-_____ Extension : _____

E-mail address : _____

Father's name : _____

Father's address : _____

City : _____Postal code : _____

Home phone number : ( ) _____-_____

Cell phone number : ( ) _____-_____

Work phone number : ( )_____ -_____ Extension : _____

E-mail address : _____

Person responsable for the account: _____

Do you have an insurance plan that covers orthodontic treatment? _____