



Family Information

Parent/ Legal Guardian Name: _____ Relationship to Child: _____

DOB: _____ Email: _____ Phone number: _____ Cell / Work/ Home

Preferred Method of Contact: Phone / Email / Text

Parent/ Legal Guardian Name: _____ Relationship to Child: _____

DOB: _____ Email: _____ Phone number: _____ Cell / Work/ Home

Preferred Method of Contact: Phone / Email / Text

Home Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone number: _____

CHILD INFORMATION

Child Name: _____ **Date of Birth:** _____

What is your child's current gender identity? (Check ALL that apply)

Male Female Transgender Male/Transman/FTM Transgender Female/Transwoman/MTF Non-binary

Decline to answer

What pronouns do you prefer that we use when talking about your child? (Check all that apply)

She/her/hers He/him/his They/them/theirs other: Please specify: _____

For families with multiple children, please list each child's name, date of birth, gender identity and pronoun below.

Child's Legal Name: _____ Preferred Name : _____

Date of birth: _____ Gender Identity: _____ Pronoun: _____

Child's Legal Name: _____ Preferred Name: _____

Date of birth: _____ Gender Identity: _____ Pronoun: _____

Child's Legal Name: _____ Preferred Name: _____

Date of birth: _____ Gender Identity: _____ Pronoun: _____



INSURANCE INFORMATION

Do you have dental benefits you would like us to file for you? Y N

Insurance Name: _____

Member Name: _____ Member Date of Birth: _____

Employer: _____ Member Soc. Sec. #: _____

ID #: _____ Group # _____ Phone: _____ Address: _____

Payment for Treatment is due at time of Service unless other arrangements have been made. Thank you.