1367-B EAST GARRISON BOULEVARD
GASTONIA, NC 28054-5144
980.320.8479
WWW.GASTONIAPEDIATRICDENTISTRY.COM

Patient Information

Child's Full Name _____ Preferred Name _____
Age _____ DOB ____ / _____ / _____ Sex: M____ F_____ Place of Birth _____
Child's Home Address_____
City _____ State ___ Zip Code _____Home Phone ( )_____
Child's Interests_____
Name of School/Day Care _____
Name of Brothers/Sisters _____
Child's Physician _____
Address _____ Phone ( )_____
What is your child's current weight? _____ What is your child's current height?_____

Parent/Guardian Information
Parent/Guardian Name _____ Relationship to Patient:_____
Social Security # _____-_____-_____ DOB _____
Employer _____ Work/Mobile ( ) _____
Parent/Guardian Name _____ Relationship to Patient: _____
Social Security # _____-_____-_____ DOB _____
Employer _____ Work/Mobile ( ) _____
Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Other
Email Address _____
How did you find out about our office? _____
Emergency Contact/Friend or Relative Not Living with You
Name _____ Phone ( ) _____
Address _____ Zip _____
Insurance Information
Insured Name _____ Relationship to Patient _____
Insured's DOB _____ Insured's Employer _____
Name of Insurance Company _____ Group Number _____

I have received the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted by law, I authorize the release of any information relating to claims filed.

_____ _____
Signature of Insured Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to Gastonia Pediatric Dentistry.

_____ _____
Signature of Insured Date