Get-Acquainted Questionnaire

OAK HARBOR PEDIATRIC DENTISTRY

Larry E. Hartman, D.D.S., M.S. Peter Cao, D.D.S., M.S

"Gently Creating Healthy Smiles"

❑ Male ❑ Female

Child's Name_______________ Preferred Name_______________ Age____ Birthdate________

Father's Name _______________ Social Security No._______________

Mother's Name _______________ Social Security No._______________

Home Address_______________ How Long?_______________
STREET CITY STATE ZIP CODE

Home Phone_______________ School_______________ Grade_______

Cell Phone _______________ Email _______________

If parents can't be reached, friend or relative to notify should an emergency arise:

Name_______________ Relationship_______________ Phone_______________

Names and ages of other children in family: Check here if seen at this office

Name_______________ Age_______ _______

Name_______________ Age_______ _______

Name_______________ Age_______ _______

Father's Occupation _______________ Business Phone_______________ Military Rank _______________

Name of Employer_______________ City_______________

Mother's Occupation_______________ Business Phone_______________ Military Rank _______________

Name of Employer_______________ City_______________

Person responsible for this account: Name_______________

Address (street/city/state/zip)_______________

Does child live with person responsible for the account? ❑ Yes ❑ No Comments_______________

Is child covered by public assistance coupons? ❑Yes ❑No Is child covered by dental insurance? ❑Yes ❑No

PRIMARY DENTAL INSURANCE CARRIER:

Insurance Company_______________ Address_______________

Employee covered under this plan_______________ Social Security No._______________

Birthdate_______________ Group No. _______________ Union or Local No. _______________

Relationship to child _______________ Effective date_______________

SECONDARY DENTAL INSURANCE CARRIER:

Insurance Company_______________ Address_______________

Employee covered under this plan_______________ Social Security No._______________

Birthdate_______________ Group No._______________ Union or Local No._______________

Relationship to child _______________ Effective date_______________

Who may we thank for referring you to our office?_______________

Address (street/city/state/zip)_______________

Oak Harbor Pediatric Dentistry may contact me via phone, text, and/or email as needed to ensure accurate patient scheduling and information as available for their dental appointments and/or dental health needs.

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I also agree to the use of anesthetics and premedications considered necessary or advisable by the dentist for the comfort and well being of the child.
I accept full financial responsibility for my child's account regardless of my ability to be reimbursed by an insurance company, ex-spouse, or any other third party.

Parent or Legal Guardian_______________ Date_______________ 20____
SIGNATURE