MAVERICK SMILES

PEDIATRIC DENTISTRY

SMILE BIG. STAND OUT. BE YOU.

New Patient Information

Welcome to Maverick Smiles! Thank you for filling out this form completely.

Today's Date _____

Patient's Name _____
Last First Middle

Patient's Date of Birth _____ Sex Male/ Female

Social Security Number _____ Preferred Name _____

Patient's Home Address _____

City _____ State ____ Zip _____ Phone # _____

School _____ Grade_____

Names and ages of siblings in family _____

Do parents live together? [ ] Yes [ ] No If not, with whom does the child reside? _____

Parent or Guardian Information [ ] Mother [ ] Father [ ] Guardian

Name _____ DOB _____ Occupation_____
Last First MI

Employer_____ Work Phone # _____

SS#_____ Home # _____ Cell # _____

Marital Status _____ E-Mail address _____

Parent or Guardian Information [ ] Mother [ ] Father [ ] Guardian

Name _____ DOB _____ Occupation_____
Last First MI

Employer_____ Work Phone # _____

SS#_____ Home # _____ Cell # _____

Marital Status _____ E-Mail address _____

Person responsible for payment of account _____ Driver's license # _____

How did you find out about our office? _____

Dental Insurance

Subscriber's Name _____ Relationship _____ Date of Birth _____

SS#_____ Employer _____

Insurance Company Name/Address _____

Group # _____ Member ID # _____

Insurance Company Phone # _____

_____ _____

Signature of Legal Consent **Date**