MOUNTAINS EDGE
PEDIATRIC DENTISTRY

New Patient Form

YOUR CHILD/CHILDREN

Name	Nickname	Birthdate	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Home Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

How did you hear about our office?_____

PARENT OR GUARDIAN INFORMATION (MOTHER OR GUARDIAN)
Name:_____ Relationship:_____

Address:_____ Email:_____

City:_____ State:_____ Zip:_____ Phone:_____

Social Security# _____-_____-_____ Birthdate:____/_____/_____ Cell Phone:_____

Employer:_____Occupation:_____Work Phone_____

May we send you a text message confirming future appointments? _____YES _____NO Cell Carrier _____

PARENT OR GUARDIAN INFORMATION (FATHER OR GUARDIAN)
Name:_____ Relationship:_____

Address:_____ Email:_____

City:_____ State:_____ Zip:_____ Phone:_____

Social Security# _____-_____-_____ Birthdate:____/_____/_____ Cell Phone:_____

Employer:_____Occupation:_____Work Phone_____

PRIMARY DENTAL INSURANCE
Insured's Name:_____ Relationship:_____

Social Security# _____-_____-_____ Birthdate:____/_____/_____ Phone:_____

Employer:_____

Insurance Company_____ Group#_____ ID#_____

Ins. Co. Address_____ City:_____ State:_____ Zip:_____

_____ Date_____
Signature of Parent or Guardian