

Welcome,

Our goal is to make your child's visit both pleasant and educational. We base our practice on preventive care. Together, we can help your child have a beautiful and healthy smile that can last a lifetime. Dr. Bob & Dr. Peg

About Your Child

Name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ [ ] Male [ ] Female  
Social Security # \_\_\_\_\_  
Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Phone # \_\_\_\_\_

About You

Your Name: \_\_\_\_\_  
Marital Status: [ ] S [ ] M [ ] D [ ] W  
Relationship to child: \_\_\_\_\_  
Your Social Security # \_\_\_\_\_  
Your Home Address: *(if different from child)*  
\_\_\_\_\_  
\_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Cell Phone # \_\_\_\_\_  
Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Work Phone # \_\_\_\_\_ Ext \_\_\_\_\_  
Whom may we thank for referring you to our office: \_\_\_\_\_

About Your Spouse

*(If you are married, please complete this section)*  
Your Spouse's Name: \_\_\_\_\_  
Their Cell Phone # \_\_\_\_\_  
Their Employer: \_\_\_\_\_  
Their Occupation: \_\_\_\_\_  
Their Work Phone # \_\_\_\_\_

Emergency Information

*(Please name someone other than spouse)*  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Cell or Work Phone # \_\_\_\_\_

Dental Insurance #1

Cardholder Name: \_\_\_\_\_  
Relationship to child: [ ] Parent [ ] Other \_\_\_\_\_  
Cardholder Birth date: \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer: \_\_\_\_\_  
Group # \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_  
\_\_\_\_\_  
Ins. Co. Phone # \_\_\_\_\_

Dental Insurance #2

Cardholder Name: \_\_\_\_\_  
Relationship to child: [ ] Parent [ ] Other \_\_\_\_\_  
Cardholder Birth date: \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer: \_\_\_\_\_  
Group # \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_  
\_\_\_\_\_  
Ins. Co. Phone # \_\_\_\_\_

I understand that the information I have given is correct. I authorize treatment of required dental services and release of information for insurance, appointment scheduling and confirmation. I understand that I am responsible for all costs of dental treatment and direct payment to Drs. Slovic & Sujack.

\_\_\_\_\_  
(Signed)

\_\_\_\_\_  
(Date)