Travis R. White, DMD
Kolby J. Lance, DMD
John C. Dryden, DMD

Welcome…

**1. Childs Name**: First _____ MI _____ Last _____
DOB: _____ Age: _____ Male/ Female
Mailing Address: _____ City/ State/ Zip _____

**Father**: _____
DOB: _____ SSN: _____
Phone: _____
Address if different from child:
_____
Email: _____
Employer:_____
Phone: _____

**Mother**: _____
DOB: _____ SSN: _____
Phone: _____
Address if different from child:
_____
Email: _____
Employer: _____
Phone: _____

Child lives with: __ Father __ Mother __ Both __ Other
Marital Status of Parents: __ Married __ Single __ Divorced __Separated __Widowed

If appropriate- Name of legal Guardian: _____ Phone: _____
Emergency Contact: _____ Relationship _____ Phone: _____

**Primary Insurance**: _____
Subscriber: _____

**Secondary Insurance**: _____
Subscriber: _____

**2. Childs Name**: First _____ MI _____ Last _____
DOB: _____ Age: _____ Male/ Female
Mailing Address: _____ City/ State/ Zip _____

**Father**: _____
DOB: _____ SSN: _____
Phone: _____
Address if different from child:
_____
Email: _____
Employer:_____
Phone: _____

**Mother**: _____
DOB: _____ SSN: _____
Phone: _____
Address if different from child:
_____
Email: _____
Employer: _____
Phone: _____

Child lives with: __ Father __ Mother __ Both __ Other
Marital Status of Parents: __ Married __ Single __ Divorced __Separated __Widowed

If appropriate- Name of legal Guardian: _____ Phone: _____
Emergency Contact: _____ Relationship _____ Phone: _____

**Primary Insurance**: _____
Subscriber: _____

**Secondary Insurance**: _____
Subscriber: _____

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

**Assignment and Release**: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Rabbit Ears PLLC d/b/a/ A Kidz Dentist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature: _____ Date: _____ Relationship: _____
Please print name of Patient, Parent, Guardian/ Personal Representative: _____