Great Lakes Dental Care P.C.

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Patient Information (Confidential):

Today's Date: _____ Child's Full Name (Last, First, Middle): _____

Birth Date: _____ Gender: Male ☐ Female ☐ Social Security #: _____

Address: _____ Zip Code: _____

Home Phone: _____

Responsible Party Information:

(This person will be financially responsible for account)

Full Name (Last, First, Middle) : _____ Birth Date: _____

Social Security #: _____ Driver's License #: _____ State: _____

Relationship to Child: Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Legal Guardian ☐

If you are a divorced parent do you have legal custody of this child? Y ☐ N ☐ Employer: _____

Billing Address: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Parent(s) or Legal Guardian Information:

Father's Name: _____ Or Same As Responsible Person Above ☐

Birth Date: _____ Address if Different than Child's: _____

Home Phone: _____ Work: _____ Social Security #: _____

Mother's Name: _____ Or Same As Responsible Person Above ☐

Birth Date: _____ Address if Different than Child's: _____

Home Phone: _____ Work: _____ Social Security #: _____

Insurance Information:

Primary Insurance Company: _____ Insurance Address: _____

Group #: _____ Subscriber ID (if available): _____ Employer: _____

Name of Insured: _____ Address: _____

Insured's Birth Date: _____ Social Security #: _____ Phone number: _____

Do you have any additional insurance? Yes ☐ No ☐ If yes, please complete the following:

Secondary Insurance Company: _____ Insurance Address: _____

Group #: _____ Subscriber ID (if available): _____ Employer: _____

Name of Insured: _____ Address: _____

Insured's Birth Date: _____ Social Security #: _____ Phone number: _____