Child's Play
Pediatric Dentistry

New Patient Questionnaire

TODAY'S DATE: DD / MMM/ YYYY

CHILDS DATE OF BIRTH (DD/MMM/YYYY)

☐ Female ☐ Male

FIRST | MIDDLE | LAST NAME

PREFERRED NAME | CARE CARD / PHN

REFERRAL INFORMATION – HOW DID YOU HEAR ABOUT US? SPECIFY DOCTOR / PRACTICE IF KNOWN

PARENT / GUARDIAN – FIRST & LAST NAME	**PARENT / GUARDIAN – FIRST & LAST NAME**
PARENT / GUARDIAN DATE OF BIRTH (DD/MMM/YYYY) M ☐ F ☐	PARENT / GUARDIAN DATE OF BIRTH (DD/MMM/YYYY) M ☐ F ☐
☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED ☐ WIDOWED ☐ OTHER	☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED ☐ WIDOWED ☐ OTHER
STREET ADDRESS	STREET ADDRESS
CITY / POSTAL CODE	CITY / POSTAL CODE
CELL PHONE NUMBER / HOME / ALT NUMBER	CELL PHONE NUMBER / HOME / ALT NUMBER
PLACE OF EMPLOYMENT	PLACE OF EMPLOYMENT
BUSINESS NUMBER / EMAIL ADDRESS	BUSINESS NUMBER / EMAIL ADDRESS

IN THE EVENT OF EMERGENCY AND PARENT CANNOT BE REACHED

NOTIFY FULL NAME / RELATIONSHIP	CONTACT PHONE

DENTAL INSURANCE INFORMATION

POLICY HOLDER	POLICY HOLDER
INSURANCE NAME	INSURANCE NAME
CERTIFICATE / ID # / GROUP / POLICY #	CERTIFICATE / ID # / GROUP / POLICY #