CHILD'S INFORMATION

Child's Last Name:	First Name:	Preferred:	Middle:	Sex: Male ☐ Female ☐

Date of Birth:	Age:	SS#:	Home Phone #:

Child's Mailing Address:	City:	State:	Zip:
Child's Physical Address:	City:	State:	Zip:

MOTHER'S INFORMATION

Mother's Last Name:	First Name:	Middle:	DOB:

Mother's SS#:	Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐	Biol. Mother ☐	Step-Mother ☐	Guardian ☐

Mother's Employer:	Home Phone:	Cell Phone:	Work Phone:

Mother's Address:	City:	State:	Zip:	Email:

FATHER'S INFORMATION

Father's Last Name:	First Name:	Middle:	DOB:

Father's SS#:	Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐	Biol. Father ☐	Step-Father ☐	Guardian ☐

Father's Employer:	Home Phone:	Cell Phone:	Work Phone:

Father's Address:	City:	State:	Zip:	Email:

Person Responsible For Bill:	Date of Birth:	SS#:	Phone (If Different):

PRIMARY INSURANCE

Insured's Name:	
Insured's Date of Birth:	
Insurance Co.:	
Insurance Co. Phone:	
ID#:	Group#

SECONDARY INSURANCE

Insured's Name:	
Insured's Name:	
Insurance Co.:	
Insurance Co. Phone:	
ID#:	Group#:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I give River City Dental, Inc. permission to leave messages and/or other pertinent information at my home, and/ or voice mail, e-mail or at my place of employment per my request. Initials: _____

I, _____, have been provided access to a copy of this office's Notice of Privacy Practices.
Print Name

_____ _____
Signature Date