Welcome to Valley Kids Pediatric Dentistry!

***Please fill out the following information and return the forms by email to office@valleykidsteeth.com prior to your child's dental appointment (Please submit a separate form for each child).

Patient's Information:

Patient's Legal Name: _____
Patient's nickname:_____ DOB: _____
Gender_____ Pronouns:_____
Address: _____City: _____Zip Code: _____
Physician/Medical Group Name: _____
Previous Dentist:_____

Responsible party/ guardian #1:

Name:_____ DOB:_____
Relationship to patient: _____
Is this individual the patient's legal guardian? Y or N, If N explain:_____
Is this individual the emergency contact? Y or N, If N explain:_____
Marital status: ___ Single ___Married __Divorced
Home address: __Same as Patient
_____City:_____Postal Code:_____
Is this also the mailing address? Y or N, _____
Responsible party cell phone #: _____
Responsible party email address: _____

Guardian #2 (if applicable)

Name:_____ DOB:_____
Marital status: ___ Single ___Married __Divorced
Home address: ___ Same as patient
_____ City:_____
Postal Code:_____ Phone #(if diff)_____
Relationship to the patient:_____
May we contact this individual regarding the patient's dental care: Y/N

Primary Insurance Info: (all fields required)

Insurance Company: _____
ID Number: _____
Group Number: _____
Policy Holder:_____
DOB of Policy Holder:____/____/____
Employer Name:_____

Secondary Insurance Information (if applicable):
Insurance Company: _____
ID Number: _____
Group Number: _____
Policy Holder:_____
DOB of Policy Holder:____/____/____
Employer Name:_____

Whom may we thank for referring to you?_____

—----------Please sign and date below—----------

****By signing this form I agree that the information provided in this form is correct to the best of my knowledge***

_____ _____
Signature Date