

# Child Acquaintance Form

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Preferred Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  Unspecified

How did you hear about us? \_\_\_\_\_ If referred by a friend or dentist, who? \_\_\_\_\_

Other siblings and their birth dates \_\_\_\_\_

Child's School \_\_\_\_\_ Hobbies \_\_\_\_\_

Patient resides with:  Mother & Father  Father  Mother  Other: \_\_\_\_\_

**Primary Contact** (*Guardian at Appointment*)  Mother  Father  Other \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Orthodontic Insurance? Yes / No

Marital Status  Single  Married  Divorced  Separated  Widowed SS# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Length at Current Job \_\_\_\_\_

Best Contact Number \_\_\_\_\_ Number is a  Cell  Home  Work

Additional Contact Number \_\_\_\_\_ Number is a  Cell  Home  Work

Email Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

If you have lived at your current address for less than three years, please also put your prior address below:

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Secondary Contact** (*Additional Guardian*)  Mother  Father  Other \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Orthodontic Insurance? Yes / No

Marital Status  Single  Married  Divorced  Separated  Widowed SS# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Length at Current Job \_\_\_\_\_

Best Contact Number \_\_\_\_\_ Number is a  Cell  Home  Work

Additional Contact Number \_\_\_\_\_ Number is a  Cell  Home  Work

Email Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

If you have lived at your current address for less than three years, please also put your prior address below:

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

- I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence
- I understand that, when appropriate, credit bureau reports may be obtained
- I authorize the staff to perform necessary orthodontic services during the initial consultation
- I authorize that photos taken may be used in journals, promotional materials, and on websites/social media and are the property of The Big Smile Orthodontics
- I authorize release of any information relating to an Insurance claim
- I authorize payment directly, when applicable, to the office of The Big Smile Orthodontics
- I consent to the practice using my cell phone to contact me regarding appointments, treatment, insurance, and my account

SIGNATURE (parent or guardian) \_\_\_\_\_ Date \_\_\_\_\_