CRITCHFIELD DENTAL
RESTORATIVE & COSMETIC DENTISTRY

18275 N. 59th Ave. D-120
Glendale, AZ 85308
Phone 602-943-7204
Fax 602-943-1534
frontdesk@critchfielddental.com

CHILD PATIENT INFORMATION

Child's Full Name _____ Date of Birth _____

Child's Preferred Name _____ School District _____

Mother's Contact Preference(s) Cell Home Work Text Email

Father's Contact Preference(s) Cell Home Work Text Email

MOTHER'S INFORMATION

Name _____

Address _____

City _____ State ___ Zip _____

Birthdate _____ Sex M F

Social Security # _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Occupation _____

Single Married Divorce Widowed

FATHER'S INFORMATION

Name _____

Address _____

City _____ State ___ Zip _____

Birthdate _____ Sex M F

Social Security # _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Occupation _____

Single Married Divorce Widowed

Whom does the child live with? _____

Whom may we thank for referring you? _____

Person to Contact for Emergency _____

Relationship to Patient _____ Emergency Contact Phone _____

DENTAL INSURANCE

PRIMARY CARRIER

Insurance Co _____

Subscriber _____

Relationship to Subscriber: Child Other

Subscriber ID or SS# _____

Subscriber Birthdate _____

Employer _____

Group # _____

SECONDARY CARRIER

Insurance Co _____

Subscriber _____

Relationship to Patient: Child Other

Subscriber ID or SS# _____

Subscriber Birthdate _____

Employer _____

Group # _____