BOUDREAU FAMILY DENTAL
SMILE CARE FOR LIFE

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CHILD INFORMATION AND BILLING

YOUR CHILD'S INFORMATION

Child's Name: ______________________________ Date: ______________
SS # / SIN: ______________ Birthdate: ______________ Home Phone: ______________
Address: ______________ City: ______________ State: ________ Zip: ________
School: ______________ Grade: ______________ Sex: ________ Age: ________

RESPONSIBLE PARTY

Name: ______________________________ Relationship to Patient: ______________
Address: ______________ City: ______________ State: ________ Zip: ________
Email: ______________ Home Phone: ______________ Cell Phone: ______________
SS # / SIN: ______________ DL #: ______________ Work Phone: ______________
Who is responsible for making appointments? ______________________________

PARENT OR GUARDIAN INFORMATION ❏ MOTHER ❏ FATHER ❏ GUARDIAN

Name: ______________________________ Home Phone: ______________
Email: ______________ Work Phone: ______________ Cell Phone: ______________
Employer: ______________________________ Occupation: ______________
SS # / SIN: ______________ DL #: ______________
Marital Status ❏ Single ❏ Married ❏ Separated ❏ Divorced ❏ Widowed

PRIMARY INSURANCE INFORMATION

Name of Insured: ______________________________ Relationship to Patient: ______________
SS # / SIN: ______________ Birthdate: ______________ Date Employed: ______________
Name of Employer: ______________________________ Occupation: ______________
Insurance Company: ______________ Group #: ______________ Policy/ ID #: ______________
Ins. Company Address: ______________ City: ______________ State: ________ Zip: ________

Do you have any additional insurance? ❏ Yes ❏ No If yes, please complete the following:

Name of Insured: ______________________________ Relationship to Patient: ______________
SS # / SIN: ______________ Birthdate: ______________ Date Employed: ______________
Name of Employer: ______________________________ Occupation: ______________
Insurance Company: ______________ Group #: ______________ Policy/ ID #: ______________
Ins. Company Address: ______________ City: ______________ State: ________ Zip: ________