**Family Information**

Parent/ Legal Guardian Name: Relationship to Child: ­­­­­

DOB: \_\_\_ Email: \_\_\_\_\_\_\_\_\_­ Phone number: Cell / Work/ Home

Preferred Method of Contact: Phone / Email / Text

Parent/ Legal Guardian Name: Relationship to Child:

DOB: \_\_\_ Email: \_\_\_\_\_\_\_\_\_ Phone number: Cell / Work/ Home

Preferred Method of Contact: Phone / Email / Text

Home Address:

City: State: Zip Code:

Emergency Contact: Phone number: \_\_

**CHILD INFORMATION**

**Child Name**: Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your child’s current gender identity? (Check ALL that apply)

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Non-binary

 ☐ Decline to answer

What pronouns do you prefer that we use when talking about your child? (Check all that apply)

☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ other: Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For families with multiple children, please list each child’s name, date of birth, gender identity and pronoun below.

Child’s Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_ Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_ Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_ Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Do you have dental benefits you would like us to file for you? Y N

Insurance Name:

Member Name: Member Date of Birth: \_\_\_\_\_\_

Employer: Member Soc. Sec. #: \_\_\_\_\_\_

ID #: Group # Phone: Address:

Payment for Treatment is due at time of Service unless other arrangements have been made. Thank you.