

Pediatric Dentistry of The Treasure Coast

1316 SE Port St Lucie Blvd, Port St Lucie, FL 34952 | (772) 337-0899 | www.drarias.com

Patient Information

Patient Name: _____ Date: _____

Gender: M or F Birth Date: _____ Social Security: _____

Driver's License#: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: Home _____ Work _____ ext: _____

Fax: _____ Cell: _____

Family Information

Mother's Name: _____ Date: _____

Responsible Party: Yes or No Birth Date: _____ Social Security: _____

Driver's License#: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: Home _____ Work _____ ext: _____

Fax: _____ Cell: _____

Father's Name: _____ Date: _____

Responsible Party: Yes or No Birth Date: _____ Social Security: _____

Driver's License#: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: Home _____ Work _____ ext: _____

Fax: _____ Cell: _____

Do you have dental insurance that will reimburse you for your child's appointment? Yes or No

Stepmother's Name: _____ Do you have legal custody of the child? Yes or No

Stepfather's Name: _____ Do you have legal custody of the child? Yes or No

Employment Information

The following is for: The Patient The Person responsible for payment

Employer Name: _____ Address: _____

Signature: _____ Date: _____

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Insurance Information

Primary

Name of Insured: _____ Date: _____

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____

Insured Employer Name: _____

Address: _____

Patient's relationship to insured: _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Date: _____

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____

Insured Employer Name: _____

Address: _____

Patient's relationship to insured: _____

Insurance Plan Name and Address: _____

Get Acquainted Questionnaire

List names and ages of brothers and sisters:

Child's favorite Pets and Animals:

Hobbies or Activities:

Whom may we thank for referring your child to our office?

Emergency Contact:

Phone:

Relationship:

Signature: _____ Date: _____