Jessica Phillips, DMD
east tennessee pediatric dentistry
specializing in the care of infants, children, and adolescents

Child's Information (Patient)

Name_____ Nickname_____

Address_____ Birthdate_____ Sex_____

City/ State/ Zip_____ School_____

Social Security #_____

Chief Complaint_____

Whom may we thank for referring you to our office?_____

Father/ Guardian/ Stepfather (circle one)

Name_____

Address_____

City/State/ Zip_____

Home Phone (____)_____

Cell Phone (____)_____

Employer_____

Business phone if OK to call (____)_____

Social Security #_____

Date of Birth_____

Email_____

Mother/ Guardian/ Stepmother (circle one)

Name_____

Address_____

City/State/ Zip_____

Home Phone (____)_____

Cell Phone (____)_____

Employer_____

Business phone if OK to call (____)_____

Social Security #_____

Date of Birth_____

Email_____

Person responsible for the account:_____

Emergency Information: If we are unable to contact the parent, whom should we contact?
(DO NOT LIST YOURSELF OR SPOUSE)

Name_____ Relationship_____ Phone_____

Insurance Information

Primary Dental Insurance

Cardholder Name_____

Date of Birth_____

Employer_____

Insurance Co._____

Group ID#_____

Ins. ID#_____