



## Kansas City Pediatric Dentistry

3801 Southwest Trafficway • Kansas City, MO 64111 • (816) 622-2000

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR TREATMENT AND UNDERSTANDING OF YOUR CHILD.  
THANK YOU FOR COMPLETING IT IN FULL.

### Family Registration

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient's Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street City State Zip

Parent/Guardian's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Employer/Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell \_\_\_\_\_ E-mail address \_\_\_\_\_

Parent/Guardian's Dental Insurance \_\_\_\_\_  
Company Address Policy #

Parent/Guardian's Major Medical Insurance \_\_\_\_\_  
Company Address Policy #

Other Parent/Guardian's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Employer/Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell \_\_\_\_\_ E-mail address \_\_\_\_\_

Parent/Guardian's Dental Insurance \_\_\_\_\_  
Company Address Policy #

Parent/Guardian's Major Medical Insurance \_\_\_\_\_  
Company Address Policy #

Phone number for confirmation \_\_\_\_\_ E-mail for confirmation \_\_\_\_\_

With whom does patient live? \_\_\_\_\_ Is your child adopted? \_\_\_\_\_

Other Children in family- names and ages \_\_\_\_\_

Parent's Dentist \_\_\_\_\_

Whom may we thank for referring you to our office?  Doctor  Friend  Website  Other \_\_\_\_\_

Reason for Dental Visit?  1st visit (new patient)  New to area  Changed dentists

What is the primary language spoken in the child's home? \_\_\_\_\_

Please provide a person we may contact in case of an emergency:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_