THE BEACH HOUSE

PEDIATRIC
DENTISTRY & ORTHODONTICS

New Patient Information

Patient Name: ____________________ Date of Birth: ________________________

Home Address: ___________________ Phone Number: _____________________

Alt Phone Number: _______________ Email Address: _______________________

If Patient is a Student, name of school:

____

Whom may we thank for referring you?

____

Responsible Party:

Name: _________________________ Date of Birth: _____________________

Relationship: ___________________ Employer: ________________________

Name: _________________________ Date of Birth: _____________________

Relationship: ___________________ Employer: ________________________

Reason for Today's Visit:

____

____

___________________________________ _____________________________

Signature (Patient, Parent or Guardian) Date