Carolyn A. Loughlin, D.D.S.

Diplomate, American Board of Pediatric Dentistry

Healthy Young Smiles

Patient Information

Patient: _____ Today's Date: _____

Nickname/ Preferred Name: _____ Date of Birth: _____ Age: ____ Sex: M F

School: _____ Grade: _____

Home Address: _____ City: _____ Zip: _____

Phone Number: _____ Social Security Number: _____

Who has legal custody of this patient? _____

Patient's Hobbies, Interests, or Pets: _____

How do you think your child will respond to dental treatment? _____

Reason for today's visit: _____

E-mail Address: _____
May we contact you via email or text for appointment reminders and/or account statements? yes no

Mother's Information
Name: _____ Date of Birth: _____ Social Security #: ____ - ____ - ____

Occupation: _____ Employer: _____ Driver's License #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father's Information
Name: _____ Date of Birth: _____ Social Security #: _____

Occupation: _____ Employer: _____ Driver's License #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Financial and Insurance Information

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship to patient: _____
Billing Address: _____ City: _____ Zipcode: _____
Work Phone: _____ Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION
Dental Insurance Company: _____ Phone: _____
Name of Insured: _____ ID#: _____ DOB: _____
Group/Policy #: _____ Employer: _____