

*GREGORY L. SAWYER, D.D.S.*  
*MATTHEW A. DIERCKS, D.D.S.*

WELCOME TO OUR PRACTICE!

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**ABOUT YOUR CHILD**

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Today's Date: \_\_\_\_\_

**Childs Name:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_

                    Last                      First                      Mi  
Birthdate: \_\_\_/\_\_\_/\_\_\_   Age: \_\_\_\_\_   Social Security #: \_\_\_\_\_    Male    Female

School attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Other Family members seen by us: \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

Home Address: \_\_\_\_\_

                    Street                      City                      State                      Zip  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Driver License #: \_\_\_\_\_

Do you have legal custody of this child? \_\_\_\_\_ Where & When are best times to reach you? \_\_\_\_\_

**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address \_\_\_\_\_

                    Street/PO box                      City                      State                      Zip

**Parent/Guardian Name:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

Home Address: \_\_\_\_\_

                    Street                      City                      State                      Zip  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Driver License #: \_\_\_\_\_

Do you have legal custody of this child? \_\_\_\_\_ Where & When are best times to reach you? \_\_\_\_\_

**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address \_\_\_\_\_

                    Street/PO box                      City                      State                      Zip

**Person Responsible for account**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

                    Street                      City                      State                      Zip

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**INSURANCE INFORMATION**

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**Primary Dental Insurance**

Insurance Company Name \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group/ Policy #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

                    Street/PO box                      City                      State                      Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

Insured's Birth Date \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

                    Street/PO box                      City                      State                      Zip

**Secondary Dental Insurance**

Insurance Company Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group/ Policy #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

                    Street/PO box                      City                      State                      Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

Insured's Birth Date \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

                    Street/PO box                      City                      State                      Zip

