# Alan K. Kuwabara, D.D.S.
# Child & Adolescent Dentistry

***Welcome to our office! Please fill out this form completely in ink prior to treatment.***

**Child's Information**

Child's name: ______________________________ Name child goes by: ______________
Last First Initial

Date of Birth: ______________

Birth Sex: F[ ] M[ ] Gender Identity:____________ Preferred Pronouns:______________

Street: ________________________ City: ____________ State: ____ Zipcode: ________

School: ______________________

Referred By: ____________________

Who is accompanying the child today? ________________ Relationship: ______________

Do you have legal custody/guardianship of this child? _____ Explain: ______________

Who is responsible for the account?________________ Relationship: ______________

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**Parent #1 Information** (Primary Contact) [ ] Mother [ ] Father [ ] Guardian

Name: ______________________ DOB: ____________ SS#: ______________

Address (if different from child): ________________________________

Home#: ______________ Work#: ______________ Cell#: ______________

Email: ______________________

Employer: ________________

Dental Insurance Co.: ______________ Address: ______________________

Subscriber ID #: ______________ Group #: ____________ [ ] Primary [ ] Secondary

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**Parent #2 Information** (Secondary Contact) [ ] Mother [ ] Father [ ] Guardian

Name: ______________________ DOB: ____________ SS#: ______________

Address (if different from child): ________________________________

Home#: ______________ Work#: ______________ Cell#: ______________

Email: ______________________

Employer: ________________

Dental Insurance Co.: ______________ Address: ______________________

Subscriber ID #: ______________ Group #: ____________ [ ] Primary [ ] Secondary

# PATIENT INFORMATION