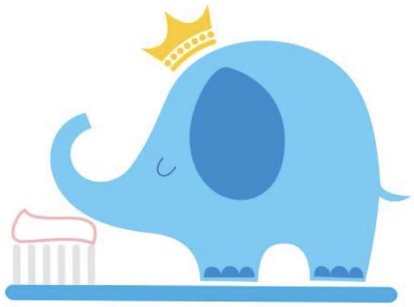

Knightsville Pediatric Dentistry

smile@knightsvillekids.com (843) 771-2003 852 Orangeburg Rd, Summerville, SC 29483

NEW PATIENT INFORMATION

Please let us know about your child's dental and medical history so we may serve you more effectively and in a manner that helps with the overall health and well-being of your child. We realize that not all questions will pertain to your child. If you have any questions, please ask and we will help to better explain the question.

Guardian's Last Name: Guardian's First Name:

Relationship to Child:

Child's Last Name: Child's First Name:

Preferred Name: Birth Date:

Gender: Unknown

Phone Number: Other Phone Number:

Email Address:

Address:

Previous Dental Visit (name of practice, city/state, and estimated date):

Estimated Date of Last Panorex X-Ray:

Estimated Date of Last Bitewings X-Ray:

Name and ages of other children in the family.

Does your family have any pets?

Hobbies/Sports:

Who does your child live with?

What is the reason for your child's visit with Dr. June Murakaru-McCollum today?

Has your child seen Dr. June Murakaru-McCollum at a different practice previously?

☐ Yes ☐ No

Has your child had any trauma to his or her teeth? If yes, please explain:

Has your child experienced any unfavorable reactions from previous dental or medical care?
If yes, please explain:

Is there anything else that Dr. June and staff would need to know about your child in order to provide them with the best possible care?

Whom may we thank for referring you to our practice?

Do we have permission to use your child's photo online for promotions, marketing, and social media purposes?

☐ Yes ☐ No

The parent or guardian who accompanies this child to the appointments is responsible for payment at the time of service.

By signing below, I, being the parent (or guardian) of, Bob TEST, do hereby authorize and request the performance of dental services upon the person named above.

By signing below, I understand that I am financially responsible for all charges not covered by insurance.
I authorize the use of this electronic signature on all insurance submissions.
I understand that Knightsville Pediatric Dentistry will submit my child's insurance claims as a courtesy.
I understand that all treatment plans are an estimate of benefits and not a guarantee of payment.
I understand that if my insurance company processes any claim incorrectly and mistakenly pays the subscriber that I will owe that amount to Knightsville Pediatric Dentistry.

Type Name Here:

Sign Here: