Welcome to Super Smiles Dentistry. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

Patient Information

Last Name First Name Middle Initial Preferred:

Gender: Male: ☐ Female: ☐

Birthdate Social Security Number

Home Phone Cell Phone

Email

Address

How did you hear about us?

City State Zip Code

Would you like to recieve text messages via cell phone to remind you of your appointment(s)? Yes ☐ or No ☐

Emergency Contact: Number:

Responsible Party

Name of Person Responsible For this Account Relation to patient:

Address (if different then patients) City State Zip Code

☐ Married ☐ Widowed

Social Security Number Birthdate

☐ Divorced ☐ Single

Employer Work Phone

I authorize for Super Smiles Dentistry to release any information or records about me or my child to the following:

Note: Please list any and all schools, daycares, doctors, friends or family who we may release info to.

Daycares/Schools	Pediatricans/Doctors/Dentists
1.)	1.)
2.)	2.)

Friends/Family	Relation to Patient
1.)	1.)
2.)	2.)
3.)	3.)

Parent/Guardian Signature: