



Monique D. McEachern, DDS, PLLC
Dentistry for infants, children and teens

Patient Information

Patient's Full Name _____ Name Called _____
Age ___ Birthday ___ / ___ / ___ Sex: M ___ F ___ Place of Birth _____
Home Mailing Address _____
City _____ State _____ Zip Code _____ Home Phone _____
Child's Favorite Hobbies/Interests _____
Name of School/DayCare _____
Brothers / Sisters (Names & Ages) _____
Child's Physician _____ Phone _____
Address _____ Date last exam _____
Child's Current Weight _____
How did you find out about our dental office? _____

Parent/Guardian Information

Parent/Guardian Name _____ Relationship to Patient _____
Social Security # _____ Birthdate _____ Driver's License # _____
Employer _____ Occupation _____
Work Phone _____ Cell Phone _____ Email Address _____
Parent/Guardian Name _____ Relationship to Patient _____
Social Security # _____ Birthdate _____ Driver's License # _____
Employer _____ Occupation _____
Work Phone _____ Cell Phone _____ Email Address _____

Emergency Contact/Friend or Relative Not Living with You

Name _____ Phone _____
Address _____ Zip Code _____

Dental Insurance Information

Primary Insured's Name _____ Insured's Soc. Sec. No. _____
Insured's Birthdate _____ Insurance Co. _____ Group No. _____
Subscriber No. _____ Primary Insured's Employer _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.
Signed Employee/Subscriber- _____