EXPEDITION
PEDIATRIC DENTISTRY

Patient Information

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Preferred Name/Nickname (if different from above): _____

Date of Birth: _____ ☐ Male ☐ Female Ethnicity: _____

Home Address: _____
Street

_____ _____ _____
City State Zip

Child's school: _____ Grade: _____ Preferred Language: _____

Child's Hobbies/Interests: _____

_____

LEGAL PARENT/GUARDIAN INFORMATION

Last Name: _____ First Name: _____ MI: _____

Preferred Name/Nickname (if different from above): _____

Date of Birth: _____ ☐ Male ☐ Female Relationship to Child: _____

Primary Phone: _____ ☐ Home ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Cell ☐ Work

Email Address: _____

LEGAL PARENT/GUARDIAN INFORMATION

Last Name: _____ First Name: _____ MI: _____

Preferred Name/Nickname (if different from above): _____

Date of Birth: _____ ☐ Male ☐ Female Relationship to Child: _____

Primary Phone: _____ ☐ Home ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Cell ☐ Work

Email Address: _____

This section is to be used for providing your authorization for our office to speak with designated authorized individuals (family, caretakers, etc.) about your child's dental treatment under HIPAA. Please list anyone (besides the parent/guardians listed above) that has permission to discuss treatment and care of your child. Anyone not listed in this section will not be provided any information about your child.

1. Name: _____ Date of Birth: _____
   Relationship: _____ Phone Number: _____
2. Name: _____ Date of Birth: _____
   Relationship: _____ Phone Number: _____
3. Name: _____ Date of Birth: _____
   Relationship: _____ Phone Number: _____

By signing this form, I am confirming my authorization that Gardner Pediatric Dentistry may use and disclose my child's Protected Health Information to the persons named on this form.

Signature of Parent/Legal Guardian: _____Date: _____

Printed Name:_____ Relationship to Patient:_____

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