EAST TENNESSEE ENDODONTICS

MINOR PATIENT

PLEASE PRINT LEGIBLY

PERSONAL INFORMATION

First Name: Middle Initial: Last Name:

Nickname: Gender: ☐ Male ☐ Female Date of Birth:

Mailing Address: Apt/Suite #:

City: State: ZIPCODE:

Referring Doctor: General Dentist:

RESPONSIBLE PARTY INFORMATION

☐ Parent (Relationship _____) ☐ Legal Guardian	☐ Parent (Relationship _____) ☐ Legal Guardian
Name:	**Name:**
Cell:	**Cell:**
Address: (if different from Child)	**Address:** (if different from Child)
Date of Birth:	**Date of Birth:**
Driver's License:	**Driver's License:**
Employer:	**Employer:**
Occupation:	**Occupation:**
Work #:	**Work #:**
Email:	**Email:**

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE	SECONDARY INSURANCE, IF APPLICABLE
Primary Subscriber:	**Primary Subscriber:**
Subscriber's Date of Birth:	**Subscriber's Date of Birth:**
Subscriber's Employer:	**Subscriber's Employer:**
Insurance Company:	**Insurance Company:**
Mailing Address: **City, State, Zip:**	**Mailing Address:** **City, State, Zip:**
Insurance Phone #:	**Insurance Phone #:**
Group #:	**Group #:**
Member ID#:	**Member ID/SSN#:**
Member SS #:	**Relationship to Patient:**
Relationship to Patient:	**Relationship to Patient:**

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