



Pleasant
Pediatric
Dentistry

GREGORY WHELAN, DMD

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DATE: _____

HOW DID YOU HEAR ABOUT US? _____

PATIENT INFORMATION

Last Name: _____

First Name: _____

Date of Birth: ____/____/____

Age (years): _____ Sex: _____

Address: _____

City: _____ Zip: _____

Phone #: (____) _____

Cell #: (____) _____

What school do they go to: _____

Siblings: _____ DOB: ____/____/____

DOB: ____/____/____

Reason for Visit: _____

Patient in Pain? Yes _____ No _____ Swelling? Yes _____ No _____

Pets? If so, what type and what are their names: _____

PARENTAL INFORMATION

Mother

Name: _____

Email: _____

Employer: _____

Employer Phone: (____) _____

Father

Name: _____

Email: _____

Employer: _____

Employer Phone: (____) _____

Complete if different from child:

Home Address: _____

City: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____

Insurance Phone: (____) _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____

DOB: ____/____/____ SS#: _____

Secondary Insurance

Insurance Company: _____

Insurance Phone: (____) _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____

DOB: ____/____/____ SS#: _____

EMERGENCY INFORMATION

Name: _____ Relationship to Patient: _____

Phone: (____) _____