Shawna Billick-Gerling D.D.S.
21714 Hardy Oak, Suite 102 ● San Antonio, Texas 78258 ● 210.497.8787 ● Fax 210.495.6866
www.littleteethoftexas.com

Welcome to our practice! We strive to make each child's visit pleasant and comfortable. Our goal is to teach your child oral habits that will help keep their smile healthy for their lifetime.

New Patient Questionaire

Your Child

Child's Name ________________________ Nickname_________________ Date of Birth ______________

Age ___________ Sex __________ Social Security________________________ School _______________

Grade ____________ Child's home address ____

City, State and Zip ____ Home Phone___________________

Child lives with ________________________________ Names of siblings __________________________

Father

Stepfather _____ or Guardian ___ (Must provide proof of guardianship.)

Name ____ Address ____________________________________

Employer ____________________________________ Occupation _________________________________

Social Security______________________ DL____________________ Date of Birth _________________

Phone #'s: Home_____________________ Work _____________________ Cell ____________________

Are you custodial parent? ____Yes ____No

Mother

Stepmother____ or Guardian ____ (Must provide proof of guardianship.)

Name ____ Address ____________________________________

Employer ____________________________________ Occupation _________________________________

Social Security______________________ DL____________________ Date of Birth _________________

Phone #'s: Home_____________________ Work _____________________ Cell ____________________

Are you custodial parent? ____Yes ____No

Parent's Marital Status:

_____ Single _____Married _____Divorced _____Widowed _____Separated

Who is responsible for making appointments? _________________ Phone ______________

How did you hear about our office?

Referral _________ Whom may we thank?____

Yellow Pages ______ Drive By _______ Welcome Home ______

Neighborhood News ______ Kids Directory ______ Business Card ______

Other ____

In case of an emergency, whom may we contact?

Name of: ___Friend ___Relative ___________________________________

Phone Numbers ____

Primary Dental Insurance

Insured's Name _____________________________________ Relationship to Patient _________________

Date of Birth _______________________ Social Security Number ________________________________

Employer __________________________________ Occupation __________________________________

Insurance Company _____________________________ Group Number ____________________________

Insurance Company Address ____

Verification of Eligibility Phone Number ____

Additional or Secondary Insurance

Insured's Name _____________________________________ Relationship to Patient _________________

Date of Birth _______________________ Social Security Number ________________________________

Employer __________________________________ Occupation __________________________________

Insurance Company _____________________________ Group Number ____________________________

Insurance Company Address ____

Verification of Eligibility Phone Number ____

For your convenience, we offer the following methods of payment. Please check the option that you prefer. Payment in full at each appointment.

____Cash ____Personal Check ____Credit Card

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____

Signature of Parent Date