

Thomas G. Wilson, D.D.S., P.C.
 Pediatric Dentist/Orthodontist
 Denise N. Evans, D.D.S.
 Pediatric Dentist
515-278-2333

pediatric & adolescent registration form

Date _____

Patient Information

Last Name _____ First Name _____ Middle Initial _____ Sex _____
 Prefers to be Addressed By _____ Date of Birth ____ / ____ / ____ Age (years) _____
 Address _____ Apt. # _____
 City _____ State _____ Zip _____ Home Telephone _____
 Other family members treated at this office _____

Parental Information

Circle One: Mother, Stepmother, Guardian
 Name _____
 Date of Birth ____ / ____ / ____
 Social Security # _____
 E-mail Address _____
 Cell Phone _____
 Does Patient Live With You? _____
 Employer _____
 Employer Address _____
 Work Phone _____
 Complete if DIFFERENT from patient's home information:
 Home Address _____
 City _____ State _____ Zip _____
 Home Telephone _____

Circle One: Father, Stepfather, Guardian
 Name _____
 Date of Birth ____ / ____ / ____
 Social Security # _____
 E-mail Address _____
 Cell Phone _____
 Does Patient Live With You? _____
 Employer _____
 Employer Address _____
 Work Phone _____
 Complete if DIFFERENT from patient's home information:
 Home Address _____
 City _____ State _____ Zip _____
 Home Telephone _____

Dental Insurance Information

(Please provide your insurance card to the receptionist)

Primary Insurance

Company _____
 Address _____
 City _____ State _____ Zip _____
 Insurance Telephone _____
 ID # _____
 Policy Holder's Name _____
 Relationship to Patient _____

Secondary Insurance

Company _____
 Address _____
 City _____ State _____ Zip _____
 Insurance Telephone _____
 ID # _____
 Policy Holder's Name _____
 Relationship to Patient _____

Referral Information

How did you hear about us? Dentist Family Friend Pediatrician School Presentation Web Site Yellow Pages Other
 Name of person to thank for referral _____