KULSHAN PEDIATRIC DENTISTRY

2210 Kulshan View Drive, Suite 102
Mount Vernon, WA 98273
(360) 424-3811
kulshankpd@dentalmail1.com

NEW PATIENT INTRODUCTION

Patient Last Name	First Name	Middle Initial	Nickname	
Street Address	Apt.No#	City	State	Zip
Date of Birth	Sex	Home Phone	Cell Phone	

Patient/Guardian E-mail: ____

FATHER'S NAME:	**MOTHER'S NAME:**
DOB:	DOB:
SS#:	SS#:
Phone#:	Phone#:
Employer Name:	Employer Name:
Employer Address:	Employer Address:

Minor Child lives with: both parents:____ Mother:___ Father:___ Other:_______
If needed: Legal/Physical custody agreement provided yes:___ no:___

Emergency Contact Name: ________________________________ Phone/mobile#:___________________________

Relationship to child:____________________________________

Is Child covered by DSHS coupons? Yes No

INSURANCE NAME:____________________________________
ID Number: ____
Group Number:______________________________________
Primary Insured Name: ______________________________
Primary Employer: __________________________________
Primary DOB:______________________________________
Primary Social Security#: ___________________________

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I authorize the dental staff to perform the necessary dental services needed. I understand that I am financially responsible for services not insured and for any outstanding balance. I further authorize the dentist to release any medical/dental information or other records, including x-rays, necessary to facilitate the claim process.

Parent/legal Guardian Signature **Relationship** **Date**