CALLY L. ADAMS, DDS, LLC

PEDIATRIC DENTAL CLINIC

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1325 SOUTH KIHEI ROAD, SUITE 108, KIHEI, HAWAII 96753

Welcome!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help to keep their smiles beautiful for a lifetime.

Your Child's Information:

Child's Name:_____ Nickname: _____
FIRST MIDDLE LAST

Date of Birth: _____ Age: _____ Sex: ___M / F___ Language: _____

School: _____ Grade: _____

Child's Home Address: (Street) _____

(City) _____ (State) _____ (Zip Code) _____

(Phone) _____

Mother/Stepmother/Guardian

(Please circle the appropriate title)

Parent Name:_____

Date of Birth: _____ SS# or SIN: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Email: _____

Parent's Martial Status(Please circle the appropriate status)

Single / Married / Separated / Divorced / Widowed

Father/Stepfather/Guardian

(Please circle the appropriate title)

Parent Name:_____

Date of Birth: _____ SS# or SIN: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Email: _____

Parent's Martial Status(Please circle the appropriate status)

Single / Married / Separated / Divorced / Widowed

Responsible Party

Name: _____

Relationship: _____

Address: _____

_____

SS# or SIN: _____

DL#: _____

Insurance Information

(To bill your dental insurance carrier the member ID# or employee's SS# are required)

Primary Carrier: _____ Group #: _____

Employee Name: _____ Employer: _____

Insurance ID: _____ SS#: _____

Secondary Carrier: _____ Group #: _____

Employee Name: _____ Employer: _____

Insurance ID: _____ SS#: _____