MATTHEW LAHAIR, DMD

F. EDWARD GALLAGHER, DMD

Contact & Insurance Information

Child's Name: ______________________ **Date of Birth** ____________

Address: ______________________ **City:** ____________ **Zip Code** ______

Father's Name & Address: ______________________ **Home Phone** ____________

Mother's Name & Address ______________________ **Home Phone** ____________

Phone Number to reach Mother/Father during day: ______________________

Whom may we thank for referring you: ______________________

Financial Information:

Father's Employer: ______________________ **Phone:** ____________

Work address: ______________________ **City** ____________ **Zip** ______

Mother's Employer: ______________________ **Phone:** ____________

Work Address: ______________________ **City** ____________ **Zip** ______

1. Is your child covered by dental insurance? **YES** **NO**

Name of parent insured: ______________________ **Ins. Carrier** ____________

Ins. Co. address: ______________________

Date of Birth of policy holder: ____________ **Policy#:** ____________

Social Security# ______________________ **Group#** ____________

2. Is your child covered by any other dental insurance plans? **YES** **NO**

Name of parent insured: ______________________ **Ins. Carrier** ____________

Ins. Co. address: ______________________

Date of Birth of policy holder: ____________ **Policy#:** ____________

Social Security# ______________________ **Group#** ____________

3. Is your child eligible for state assistant (Medicaid)? **YES** **NO**

Medicaid # ______________________

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