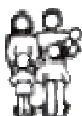

M. Wendy Holder, D.M.D., P.C.
960 Airport Drive
Alexander City, AL 35010

Welcome !

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your family's dental needs.

Patient and Family Information

Child's Name ____ Birthdate ____ Male ☐ Female ☐

Home Phone ____ Mailing Address ____

City ____ State ____ Zip Code ____

School ____ Grade ____

Relationship to Child ____

Responsible Party Information

Name ____ Birthdate ____ SS# ____

Home Phone ____ Mailing Address ____

City ____ State ____ Zip Code ____

Employer ____ Business Phone ____

Cell Phone ____ Email ____

Child's Dental and Health History (cont. on back)

Former Dentist ____ Office Phone ____

Mailing Address ____

City ____ State ____ Zip Code ____

Date of last dental visit ____ How often does your child brush? ____ floss? ____

Please check all below that apply to your child: Thumb/Finger Sucking ____ Fingernail Biting ____

Grinds Teeth ____ Lip or Cheek Biting ____ Jaw Difficulty: Clicking and/or Pain ____

Allergies ____ Diabetes ____ Hepatitis—Type ______ Tuberculosis ____ Anemia ____ Epilepsy ____

Rheumatic Fever ____ Asthma ____ HIV/AIDS ____ Scarlet Fever ____ Cancer ____

Heart Murmur ____ Tonsillitis ____ Other ________________ Other ________________

Dr. W. Holder, D.M.D., P.C.
960 Airport Drive
Alexander City, AL 35010

Primary Dental Insurance

Responsible Party Information

Person Responsible for Account ______ Relationship to Patient ______

Birthdate ______ SS# ______ Home Phone ______

Mailing Address ______

City ______ State ______ Zip Code ______

Employer ______ Occupation ______

Mailing Address ______ Business Phone ______

Insurance Company ______

Subscriber I.D.# ______ Group ______

Assignment and Release

I hereby authorize payment directly to ______________________________
for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize Dr. Holder, P.C and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________________

Date ____________________