

Children's Dentistry of Apex ♦ Ronald Venezia, DDS, MS, PA
Dental Acquaintance Form

Child Demographic Information

First Name _____ Middle Initial _____ Last Name _____ Sex: M F

Preferred Name _____ Age _____ Date of Birth ____/____/____ SSN ____-____-____

Address _____ City _____ State _____ Zip _____

Home Phone # (____) _____ Names/ages of siblings _____

Child lives with: Both parents Mother Father Other _____ Who has legal custody? _____

What is the reason for today's visit? _____

Parent Demographic Information

Father's Name _____ Father's DOB ____/____/____

Father's Social Security # ____-____-____ [or] Driver's License # _____ State _____

Home Phone # (____) _____ Work Phone # (____) _____ Cell Phone # (____) _____

Father's Employer _____

Mother's Name _____ Mother's DOB ____/____/____

Mother's Social Security # ____-____-____ [or] Driver's License # _____ State _____

Home Phone # (____) _____ Work Phone # (____) _____ Cell Phone # (____) _____

Mother's Employer _____

Referral Information

How did you hear about Children's Dentistry of Apex? (Circle all that apply)

1. Referral from a friend or relative Name: _____
2. Referral from another dentist Name: _____
3. Referral from my child's physician Name: _____
4. Telephone directory
5. Internet
6. Other (Please explain.) _____

Our practice continues to grow through referrals from our patients. We sincerely appreciate your recommending our office to your friends and neighbors.