

Mairead O'Reilly, DDS, MS, PA & Associates  
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Welcome to our practice! Please let us know a few things about you and your child for our records.

Information About Your Child:

Child's Name (First, Middle, Last): .....  
Nickname.....  
Address ( please include Apt. No., etc.):.....  
City, State, and Zip Code:.....  
Home Phone:.....  
Email Address:.....  
Social Security Number:.....  
Date of Birth:..... Sex(M/F):.....  
School and Grade:..... Hobbies:.....

Parents Information:

Father's Name (First, Middle I., Last):.....  
Address (please include Apt. No., etc.):.....  
.....  
City, State and Zip Code:.....  
Home Phone:..... Work Phone:..... Cell Phone:.....  
Email Address:.....  
Employer and Address:.....  
Social Security No.:..... Date of Birth:.....

Mother's name (First, Middle I., Last):.....  
Address (please include Apt. No., etc.):.....  
City, State and Zip Code:.....  
Home phone:..... Work Phone:..... Cell Phone:.....  
Email Address:.....  
Employer and Address:.....  
Social Security No.:..... Date of Birth:.....  
Who Will Be the Responsible Party For This Account?.....

Who Referred You To Us?.....  
Name of Child's Dentist?..... Phone No.....  
Name of your Physician?.....  
Do You Have Insurance Covering Orthodontic Treatment?.....  
If So, Name, Address of Insurance Company.....  
Group Number:.....  
Name of Subscriber For This Insurance:.....

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date