

Children's Dentistry

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A Professional Corporation
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Date _____

Patient Registration Form

- Children -

(1) Name _____ (first) _____ (Last) _____ Nickname _____
Age _____ Birthdate _____ Boy Girl (please circle)

(2) Name _____ Nickname _____
Age _____ Birthdate _____ Boy Girl

(3) Name _____ Nickname _____
Age _____ Birthdate _____ Boy Girl

Home Address _____
City/Zip _____

Home Phone _____ Cell Phone _____

E-mail Address _____

Former Address _____

Do parents and child all live together? Yes No If no, please explain _____

Separated parents: The parent/guardian present at the initial visit will be responsible for this account

I authorize routine dental procedures for my child. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and diagnostic x-rays considered necessary by the dentist for the comfort, health and well being of the child.

Parent or Legal Guardian (print) _____ SS# _____ (where appropriate, credit reports may be obtained)

Parent or Legal Guardian (signature) _____ Date: _____

Whom may we thank for referring you to this office? _____

- Parent -

Name _____

D.O.B. _____

Occupation _____

Employer _____

Business Phone _____

City _____

Emergency Contact _____ Relation _____

Address _____ Phone _____

- Parent -

Name _____

D.O.B. _____

Occupation _____

Employer _____

Business Phone _____

City _____

Relation _____

Phone _____

Insurance Information

- Primary Coverage -

Subscriber Name _____

Home Address _____

City, State, Zip _____

Social Security Number _____

Name of Plan _____

Employer _____

Employer Address - Phone Number _____

Group Number _____

Insurance Carrier _____

Insurance Address _____

- Secondary Coverage (if applicable) -

Subscriber Name _____

Home Address _____

City, State, Zip _____

Social Security Number _____

Name of Plan _____

Employer _____

Employer Address - Phone Number _____

Group Number _____

Insurance Carrier _____

Insurance Address _____