Patient Registration - Child

Welcome! Our goal is to help you have the healthiest, brightest smile possible. Please provide the following information as completely as you can. The better we communicate, the better we can care for your dental needs.

Patient Name	How do you wish to be addressed?	Date of Birth	
Address	City	State	Zip
Home Phone #	Social Security #		

Account Information

Father's Employer	Position	Work Phone # Cell Phone #
Parents' Full Names		
Mother's Employer	Position	Work Phone # Cell Phone #
Person responsible for account (address, if different from above)		

Insurance

Primary Dental Insurance Company_____

Name of Policyholder_____ Policy #_____

Primary Policyholder's birth date _____ Social Security #_____

Secondary Dental Insurance Company_____

Name of Policyholder_____ Policy #_____

Secondary Policyholders birth date _____ Social Security #_____

Someone not living with you to contact in case of emergency (name and phone):

Other family members in this practice:

How did you learn about our dental office?

If from a friend or relative, his/her name:

I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. If additional information is needed, I authorize this office to contact the appropriate health care provider or agency to obtain such information. I understand that dental insurance is a contract between the policyholder and the insurance carrier, and that I am responsible for payment of fees for services not covered in part or in whole by the insurance carrier. I authorize payment of dental insurance benefits directly to this office. The above information is correct to the best of my knowledge. Charges may be assessed if less than 48 hours notice or no notice is given when an appointment cannot be kept.

Parent Signature_____ Date _____