PATIENT REGISTRATION FORM

CHILD'S INFORMATION

Child's Name ______________________________ Middle Initial ____ Preferred Name ______________

Birthday ________________ Gender ________ Age ___ Child's Social Security # ________________

RESPONSIBLE PARTY (Main contact person for scheduling, billing and mailing address for correspondence)

Name ____ Relationship to Patient ________________

Phone Numbers H ___________________ W _____________________ C ___________________

Email ____ Birthday ______________________

Address ____

City _____________________ State ____ Zip _________ Social Security # _______________________

Employer ____________________________ Occupation _____________________________________

How may we contact you? Home Phone [ ] Cell Phone [ ] Work Phone [ ] Email [ ] Text Message [ ]

Parent's Marital Status: Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ]

ALTERNATE CONTACT

Name ____ Relationship to Patient ________________

Phone Numbers H ___________________ W _____________________ C ___________________

Email ____ Birthday ______________________

Address ____

City _____________________ State ____ Zip _________ Social Security # _______________________

Employer ____________________________ Occupation _____________________________________

PRIMARY DENTAL INSURANCE

Name of Insurance ____________________________________

Name of Subscriber ___________________________________ Insured's DOB __________________

Insured's Social Security # ________________________________

SECONDARY DENTAL INSURANCE

Name of Insurance ____________________________________

Name of Subscriber ___________________________________ Insured's DOB __________________

Insured's Social Security # ________________________________

HOW DID YOU FIND US?

Another Dentist or Doctor [ ] ____

Insurance [ ] _______________ Family/Friend [ ] _________________ Other [ ] _________________