COLORADO CHILDREN'S DENTAL CENTER
www.ccdcsmiles.com

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 ☐ _____