

Acct.# _____ Patient# _____
Prim. Ins. _____ 2ndary Ins _____
Grp#/Dental #: _____ Grp#/Dental #: _____

Date: _____
Birthdate: _____ Age: _____
Sex: Son _____ Daughter _____

Child's Name: _____ Family Name: _____
Nickname: _____ School: _____ Grade: _____
Father's Name: _____ Mother's Name: _____

Mailing Address: _____
street city zip code
(If PO. Box, street address needed) _____
street city zip code

Home Phone: _____ Cell# _____ E-mail _____
Mr. Employed by: _____ Phone: _____ Ext: _____
Present Position: _____ How long held? _____
Mrs. Employed by: _____ Phone: _____ Ext: _____
Present Position: _____ How long held? _____

Mrs. Mailing Address: _____
(if different from father) street city zip code

Married _____ Single _____ Divorced _____ Separated _____ Widowed _____
Recall or Guardian Address: _____

Person responsible for child's account: Father _____ Mother _____ Guardian _____ Other: _____
**In case of emergency, whom should be notified?: _____
(Someone not living with you) Phone#: _____ or _____
Whom may we thank for this referral ? _____

OFFICE USE ONLY

Name of employee covered under: _____
Father's Social Security No.: _____ B.D.: _____
Mother's Social Security No.: _____ B.D.: _____
HDS/OTHER: Name of Insurance Co. or Plan: _____
Grp#: _____ Coverage %: _____
Max: _____
Ortho Coverage: Yes _____ No _____
HMSA: Member No: _____ Dental Coverage Code: _____
Coverage %: _____
Max: _____
Ortho Coverage: Yes _____ No _____
MEDICAID I.D.#: _____ Effective Date: _____

OFFICE NOTE:

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting you account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release nay information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

PARENT OR GUARDIAN'S SIGNATURE _____ DATE _____

REGISTRATION