Date:_______________

Child's name:____________________ ______________________ ______ ____________________
LAST FIRST INITIAL NICKNAME

School:___________________________ Grade:_________ Birthdate:_______________ Sex:_________

Parent:_______________ _______________ ______________ SSN:_____________ DOB:________
FIRST LAST RELATIONSHIP TO PATIENT

Address:____
STREET CITY ZIP CODE

If P.O. Box, street address needed: ____

Parent Employed by:____________________________________ Position: _______________________

Cell:_______________ Home:______________ Work:____________ Email:_____________________

Parent:_______________ _______________ ______________ SSN:_____________ DOB:________
FIRST LAST RELATIONSHIP TO PATIENT

Address:____
STREET CITY ZIP CODE

If P.O. Box, street address needed: ____

Parent Employed by:____________________________________ Position: _______________________

Cell:_______________ Home:______________ Work:____________ Email:_____________________

Parent's Marital status: Married______ Single: ______ Divorced:_____ Separated:______ Widowed:______

**Person who will be the primary contact: ____

Emergency contact (not living with you): _______________________ Phone#: ____________________

Whom may we thank for this referral?____

- We invite you to discuss with us any question regarding our services. The best dental health services are based on a Friendly, mutual understanding between provider, patient, and parent.
- Our office policy requires co-payment in full for all services rendered at the time of visit, unless other arrangements have been made. If the 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 expense incurred in collecting your account.
- I authorize the staff to perform any necessary services needed for diagnosis and treatment. I also authorize the provider to release any 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 signature: ____ Date:_____________

****Please present dental insurance card and our staff will fill out the information below****

Primary insurance:________________________________ ID#:__________________________
Policy Holder:____________________________________ Policy#:_______________________

Secondary insurance:______________________________ ID#:__________________________
Policy Holder:____________________________________ Policy#:_______________________

REGISTRATION