Date: _____

Child's Name: _____
LAST FIRST INITIAL NICKNAME

Date of Birth: _____

School: _____ Grade: _____ Birthdate: _____ Sex: _____

Father: _____ SS#: _____

Address: _____
STREET CITY ZIP CODE

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

Father employed by: _____ Position: _____

Home phone: _____ Cell: _____ Work: _____ email: _____

Mother: _____ SS#: _____

Address: _____
STREET CITY ZIP CODE

If P.O. Box, street address needed: _____
STREET CITY ZIP CODE

Mother employed by: _____ Position: _____

Home phone: _____ Cell: _____ 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 and 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 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

Patient's primary insurance carrier: _____ Policy# _____ Group# _____

Policy Holder: _____ Birthdate: _____

Secondary insurance carrier: _____ Policy# _____ Group# _____

Policy Holder: _____ Birthdate: _____

REGISTRATION