Child Registration Form

Patient Information

First Name: _____ Last Name: _____ Middle Initial:_____

Birth Date: _____ Preferred Name: _____ Sex: Male____ Female ____

How did you hear about us? Google___ Yelp___ Facebook___ Friend/Relative _____Other _____
(Check all that apply)

Parent / Guardian Information

First Name: _____ Last Name: _____ Middle Initial:_____

Birth Date: _____ Soc. Sec: _____

Sex: Male____ Female ____ Marital Status: Single____ Married____ Divorced____ Other____

Address: _____City, State, Zip: _____

Cell Phone: _____ Home Phone: _____

Text and email is for appointment reminders, oral health promotion, dental record information and reminders of uncompleted treatment.
Would you like to be contacted via text? Yes_____ No_____ Would You like to be contacted via email? Yes_____ No_____

Email Address: _____

Primary Insurance

Dental Insurance Name: _____ Phone #: _____

Insurance Holder Name: _____ Date of Birth: _____

Insurance Member SS #: _____ Group #: _____

Secondary Insurance

Dental Insurance Name: _____ Phone #: _____

Insurance Holder Name: _____ Date of Birth: _____

Insurance Member SS #: _____ Group #:_____

To the best of my knowledge, the information on this is accurate and current. It is my responsibility to inform the dental office of any changes to this information.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____DATE: _____