Child Registration Form

Patient Information

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

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

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

Parent / Guardian Information (parent/legal guardian bringing child in today)

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 consent for records information, appointment reminders and other electronic communication.

Consent to communication via text? Yes_____ No_____ Consent to communication 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/GUARDIAN: _____DATE: _____