



PATIENT REGISTRATION FORM

CHILD'S INFORMATION

Child's Name _____ Middle Initial _____

Nickname _____

Family E-mail _____

Birthday _____ Gender _____ Age _____

Child's Social Security # _____

Parent's Marital Status:

Married [] Single [] Divorced [] Separated [] Widowed []

Today's Date

RESPONSIBLE PARTY (Main contact person for scheduling, billing and mailing address for correspondence)

Name _____ Relationship to Patient _____

Phone Numbers H _____ W _____ C _____

Email _____ Birthday _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Employer _____ Occupation _____

How may we contact you? Home Phone [] Cell Phone [] Work Phone [] Email [] Text Message []

ALTERNATE CONTACT

Name _____ Relationship to Patient _____

Phone Numbers H _____ W _____ C _____

Email _____ Birthday _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Employer _____ Occupation _____

PRIMARY DENTAL INSURANCE

Name of Insurance _____

Name of Subscriber _____ Insured's DOB _____

If different from responsible party, please fill out the information below:

Insured's Social Security # _____ Insured's Phone # _____

SECONDARY DENTAL INSURANCE

Name of Insurance _____

Name of Subscriber _____ Insured's DOB _____

If different from responsible party, please fill out the information below:

Insured's Social Security # _____ Insured's Phone # _____

HOW DID YOU FIND US?

Whom may we thank for referring you? Another Dentist or Doctor [] _____

Insurance [] _____ Family/Friend [] _____ Other [] _____