

Patient Registration

Please print and answer all questions.



Child's Name _____
Last First Initial Nickname

Male Female Birthdate _____ Age _____

Has any other immediate family member been treated at this office? yes no

How did you hear about our office? _____

Father's Name _____
 Step Last First Initial Nickname

Social Security No. _____ Birthdate _____ Married Separated Divorced Single

Address _____ Home Phone _____
Street or P.O. Box City State Zip

Work Phone _____ Cell Phone _____

Present Employer _____ Occupation _____

Address _____
Street or P.O. Box City State Zip

Dental Insurance Co. _____ Group No. _____

Address _____
Street or P.O. Box City State Zip

Mother's Name _____
 Step Last First Initial Nickname

Social Security No. _____ Birthdate _____ Married Separated Divorced Single

Address _____ Home Phone _____
Street or P.O. Box City State Zip

Work Phone _____ Cell Phone _____

Present Employer _____ Occupation _____

Address _____
Street or P.O. Box City State Zip

Dental Insurance Co. _____ Group No. _____

Address _____
Street or P.O. Box City State Zip

General Information

Friend or Relative _____ Phone _____

Address _____
Street or P.O. Box City State Zip

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for all claims.

I acknowledge that I am financially responsible for all charges whether or not they are paid by insurance. If I desire credit to be extended to me and/or my family for services rendered, I am aware that a credit report may be obtained before credit is extended.

Signed _____ Date _____