

*Child Patient Registration*

Patient Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Sex: M/F  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Sex: M/F  
Parent/Legal Guardian Name \_\_\_\_\_ Employer \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_  
Last Dental Exam \_\_\_\_\_ Previous Dentist \_\_\_\_\_  
Who Referred You \_\_\_\_\_ What is your chief complaint \_\_\_\_\_

PRIMARY DENTAL INSURANCE

Subscriber Name \_\_\_\_\_ Relation to patient \_\_\_\_\_  
SS# \_\_\_-\_\_\_-\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Yearly Deductible \_\_\_\_\_ Yearly Maximum \_\_\_\_\_

SECONDARY DENTAL INSURANCE

Subscriber Name \_\_\_\_\_ Relation to patient \_\_\_\_\_  
SS# \_\_\_-\_\_\_-\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_ -- \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Yearly Deductible \_\_\_\_\_ Yearly Maximum \_\_\_\_\_

Who is financially responsible \_\_\_\_\_  
Payment - Cash ( )      Check ( )      Visa/MasterCard ( )

*Full payment or your expected portion is due the day of service, unless arrangements have been made in advance.  
You agree that if it becomes necessary to forward your account to our collection agency, that, in addition to the amount owed, you will also be responsible for reasonable cost of collection, including attorney fees.*

Signature \_\_\_\_\_ Date \_\_\_\_\_