PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: ________________________ Last Name: ____________________ Middle I: ________
Preferred Name: __________________
Home Mailing Address: ____
Home Phone Number: _____________________________
Work Phone Number: _____________________________
Cell Phone Number: _______________________________
Sex: Male _____ Female: _____
Date Of Birth: ________________________
Social Security Number: _________________________________

Mother's Name (or Legal Guardian): ________________________________
Father's Name: ____
Emergency Contact Person: ________________________________
Emergency Number: ________________________________
Alternative Phone Number (Aunt, Grandparent, etc…); _________________________

Referred By: _______________________
Previous Dentist: ______________________
Last Time Your Child Saw a Dentist: ____________________

RESPONSIBLE PARTY:

Name: ______________________________ Relationship to Patient: ___________________________
Date of Birth: _____________________ Social Security Number: ___________________________
Address (if different than above): ____
Home Phone Number (if different than above): _________________________
Work Phone Number: _________________________

PRIMARY INSURANCE:

Name of Person Insured: ____
Relationship to Child (Circle): Self Parent Other
Insured Social Security Number: ________________________________
Insured Date of Birth: _________________________________
Member I.D. Number: _________________________________
Group Policy Number: _________________________________
Employer: ____
Insurance Company Name: _____________________________
Telephone # For Insurance Company: ______________________________

Child's Pediatrician and Telephone Number (if you know it): ____________________________________
____
Concerns for Today's Visit