

PATIENT REGISTRATION (CHILD)

PERSONAL INFORMATION

Today's Date: _____

Child's Name: _____ Date of Birth: _____ Age: _____ Male | Female

Father's Name: _____ Mother's Name: _____

Mailing Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____ Home Telephone: _____

Father's Work Telephone: _____ Mother's Work Telephone: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Father's Pager: _____ Mother's Pager: _____

Email: _____

Bank: _____ Branch: _____ Account No. _____

Father Employed By: _____

Present Position: _____ How Long? _____

Father's Social Security No: _____ Date of Birth: _____

Mother Employed By: _____

Present Position: _____ How Long? _____

Mother's Social Security No: _____ Date of Birth: _____

DENTAL INSURANCE INFORMATION

Father's Dental Insurance Company: _____

Group Number: _____ Insurance Company Telephone Number: _____

Mother's Dental Insurance Company: _____

Group Number: _____ Insurance Company Telephone Number: _____

GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office? Yes | No If yes, name: _____

How did you find out about our office? _____

Person to contact in case of emergency: _____ Telephone No.: _____

Closest relative not living with you: _____ Telephone No.: _____