PLEASE PRINT
PATIENT REGISTRATION

For Under 18 Years Old

OFFICE USE ONLY
DATE
UPDATED _____
_____
_____

REFERRED BY _____ DATE _____

NAME OF PATIENT _____
LAST FIRST MIDDLE NICKNAME

ADDRESS _____
STREET APT.# CITY STATE ZIP CODE

PHONE _____ AGE _____ DATE OF BIRTH _____ SEX _____

FATHER'S NAME _____
LAST FIRST MIDDLE WHERE EMPLOYED WORK PHONE

HOME ADDRESS _____
STREET APT.# CITY STATE ZIP CODE PHONE

S.S. NO _____ FATHER BIRTH DATE _____ FATHER

MOTHER'S NAME _____
LAST FIRST MIDDLE WHERE EMPLOYED WORK PHONE

HOME ADDRESS _____
STREET APT.# CITY STATE ZIP CODE PHONE

S.S. NO _____ MOTHER BIRTH DATE _____ MOTHER

NAME OF FRIEND OR NEIGHBOR WHO CAN
REACH YOU IN CASE OF EMERGENCY _____

ADDRESS _____
STREET APT.# CITY STATE ZIP CODE

METHOD OF PAYMENT: ❑ CASH ❑ CHECK

IS PATIENT COVERED BY DENTAL
INSURANCE? IF SO _____
NAME OF INS. POLICY OR ID # SUBSCRIBER'S NAME

_____
NAME OF INS. POLICY OR ID # SUBSCRIBER'S NAME

ARE YOU AWARE OF YOUR CHILD HAVING ANY
PARTICULAR DENTAL PROBLEMS? ____________________

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTAL OFFICE? ____________________

IF NOT, HOW LONG SINCE THE LAST EXAMINATION? ____________________

HAS YOUR CHILD EVER HAD ANY SERIOUS ILLNESSES SUCH AS RHEUMATIC FEVER. ANY KIND OF HEART PROBLEMS OR HEART MURMUR, DIABETES, ETC.? ____________________

❑ YES ❑ NO IF YES, WHAT? ____________________

IS YOUR CHILD SENSITIVE OR ALLERGIC TO ANY
FOOD OR MEDICATION? __________ IF SO, WHAT? ____________________

WHO IS YOUR CHILD'S PHYSICIAN? ____________________ PH# __________

IS HE/SHE UNDER ANY TREATMENT AT PRESENT?
NO __________ YES __________

WHAT MEDICATIONS DOES YOUR CHILD TAKE? ____________________

THE POLICY IN OUR OFFICE IS THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED.

SIGNATURE OF PARENT REQUESTING CARE ____________________ DATE __________

I HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE DIRECT PAYMENT TO DENTAL ASSOCIATES. I ALSO UNDERSTAND,THAT I AM RESPONSIBLE FOR ANY AND ALL UNPAID AMOUNTS.

SIGNATURE ____________________ DATE __________