Children's Center for Dentistry

Registration Form

Patient Information

First Name:_____Last Name:_____Middle Initial:_____

Address: _____Home Phone:_____

City/State/Zip:_____Cellular Phone:_____

Patient Birthdate:_____Social Security:_____

Primary Care Doctor:_____Phone Number:_____
(Pediatrician)

Responsible Party Information (Parent or Guardian)

First Name:_____Last Name:_____Middle Initial:_____

Address: _____Home Phone:_____

City/State/Zip:_____Cellular Phone:_____

Birthdate:_____Work Phone::_____

Email Address:_____ Relation to Patient:_____

Other responsible adults that may be accompanying Your Child and their relationship (i.e. parent/grandparent/guardian/relative)

_____

How did you hear about us?_____

How would you like your Appointment Reminders? PHONE CALL / TEXT / EMAIL

Insurance Information

Name of Policy Holder: (First)_____(Last)_____DOB:_____

Policy Holder Social Security Number:_____

Place of Employment:_____

Address:_____

Type of Dental Insurance: (carrier)_____

Address:_____Phone_____

Group Number:_____ ID Number:_____

Secondary Insurance Information (If applicable)

Name of Policy Holder: (first)_____(Last)_____DOB:_____

Policy Holder Social Security Number:_____

Place of Employment:_____

Address:_____

Type of Dental Insurance: (carrier)_____

Address:_____Phone_____

Group Number:_____ ID Number:_____