REGISTRATION

PATIENT _____
Last First Initial

PARENT _____
Last First Initial

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL* _____

HOME _____ WORK _____

EMAIL _____

DOB _____ SSN _____

PARENT'S EMPLOYER _____

POSITION _____

SPOUSE/OTHER PARENT _____

CELL* _____

EMPLOYER/POSITION _____

DOB _____ SSN _____

OTHER FAMILY MEMBERS IN PRACTICE _____

_____

EMERGENCY CONTACT (NOT IN HOUSEHOLD) _____

_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

_____

*Please notify us if you would like to opt out of text reminders.

PREFERRED NAME _____ DOB _____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER _____

SUSCRIBER'S DOB _____

EMPLOYER _____

INSURANCE CO. _____

INSURANCE PHONE _____

SSN OR ID # _____

GROUP # _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER _____

SUSCRIBER'S DOB _____

EMPLOYER _____

INSURANCE CO. _____

INSURANCE PHONE _____

SSN OR ID # _____

GROUP # _____

RELEASE:

I acknowledge that the above information is accurate.
I understand that all fees not covered by my insurance company are due on the day of service.
I authorize my insurance company to pay directly to the dentist.
I understand that by signing below, I am responsible for all charges for consented treatment.

Parent/Guardian _____ Date _____

PRIVACY STATEMENT:

I give permission to the doctors and staff to disseminate health information to other health care professionals that are involved in the patient's care.
I have received the practice's privacy statement.

Parent/Guardian _____ Date _____