## CHILD REGISTRATION FORM

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank you.

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| PATIENT’S LAST NAME{PATIENTSLASTNAME} | FIRST NAME{FIRSTNAME} |
| AGE{AGE} | DATE OF BIRTH{DATEOFBIRTH} | GENDER { string.Join("", GENDER ) } | HOME PHONE{HOMEPHONE} |
| HOME ADDRESS{HOMEADDRESS} |
| Mailing address if different than above:{MailingAddressIfDifferentThanAbove} |
| FATHER’S NAME{FATHERSNAME} | EMPLOYED BY{EMPLOYEDBY} |
| MOTHER’S NAME{MOTHERSNAME} | EMPLOYED BY{EMPLOYEDBY2} |
| FATHER’S WORK PHONE{FATHERSWORKPHONE} | MOTHER’S WORK PHONE{MOTHERSWORKPHONE} |
| FATHER’S CELL PHONE{FATHERSCELLPHONE} | MOTHER’S CELL PHONE{MOTHERSCELLPHONE} |
| FATHER’S DATE OF BIRTH{FATHERSDATEOFBIRTH} | MOTHER’S DATE OF BIRTH{MOTHERSDATEOFBIRTH} |
| E-Mail address{EMailAddress} |   |
| FATHER’S SS#{FATHERSSS} | MOTHER’S SS#{MOTHERSSS} |
| DATE OF LAST VISIT{DATEOFLASTVISIT} | WHAT WAS DONE THEN? {WHATWASDONETHEN} |
| HOW DID YOU HEAR ABOUT US?{HOWDIDYOUHEARABOUTUS} |
| IS THE CHILD COVERED BY DENTAL INSURANCE?{ISTHECHILDCOVEREDBYDENTALINSURANCE} |
| NAME OF INSURANCE COMPANY{NAMEOFINSURANCECOMPANY} | GROUP #{GROUP} |
| SUBSCRIBER NUMBER{SUBSCRIBERNUMBER} | PHONE #{PHONE} |
| INSURANCE COMPANY’S ADDRESS{INSURANCECOMPANYSADDRESS} |
| SUBSCRIBER NAME: {SUBSCRIBERNAME} | DATE OF BIRTH:{DATEOFBIRTH2} |
| SUBSCRIBER’S SOCIAL SECURITY #: {SUBSCRIBERSSOCIALSECURITY} |   |
|  I HEREBY AUTHORIZE & REQUEST THE PERFORMANCE OF DENTAL SERVICES FOR:{IHEREBYAUTHORIZEREQUESTTHEPERFORMANCEOFDENTALSERVICESFOR} | AGE{AGE2} |
|  Signature of Responsible Party {SignatureOfResponsibleParty} | Date{Date} |   |
| Relationship to Child{RelationshipToChild} |   |