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Registration Form

Child's Name: ______________________________ Nickname: ______________
First Middle Last

Sex: ☐ Male ☐ Female Birthdate: __________ Age: ______ School: ____________________ Grade: ______

Is this your child's first dental visit? ☐ Y ☐ N Emergency visit? ☐ Y ☐ N Reason for visit: ______________

If no, name of former dentist? ______________ Date of last visit: __________ Purpose: __________

Have any other children in your family been a patient in this office before? ☐ Y ☐ N If yes, names: __________

Has your child had any bad past dental experiences? ☐ Yes Explain: ______________

Please check any of the following that may describe your child:

☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Defiant
☐ Suspicious ☐ Moody ☐ High Strung ☐ Regular Kid ☐ Friendly ☐ Cooperative

Name of child's pet: __________ Favorite interest: __________ Favorite sport: __________

How do you expect you child to react to his visit today?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't know

How may we help to make this a positive experience for your child? ______________

Name of family dentist: ______________

Whom may we thank for referring you to our office? ______________

Parent 1: ☐ Mom ☐ Dad ☐ Other

Full Name: ______________

Address: ______________

City: __________ State: ____ Zip: ______

Phone: (____) ________Email: __________

Date of Birth: ______________

Occupation: ______________

Employer: __________ Bus. Phone: __________

Parent 2: ☐ Mom ☐ Dad ☐ Other

Full Name: ______________

Address: ______________

City: __________ State: ____ Zip: ______

Phone: (____) ________Email: __________

Date of Birth: ______________

Occupation: ______________

Employer: __________ Bus. Phone: __________

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other __________

Preferred contact method ☐ Email ☐ Text ☐ Phone ☐ Mail

Preferred recall method ☐ Email ☐ Text ☐ Phone ☐ Mail

FOR PATIENTS COVERED BY DENTAL INSURANCE

PRIMARY CARRIER

Subscriber Name: ______________

Subscriber ID#/SSN: ______________

Relationship of Patient to Subscriber: ☐ Child ☐ Self

Group/Policy Number: ______________

Employer Name: ______________

Insurance Company Name: __________ Phone: ______

How long have you had this insurance coverage? ______

SECONDARY INSURANCE

Subscriber Name: ______________

Subscriber ID#/SSN: ______________

Relationship of Patient to Subscriber: ☐ Child ☐ Self

Group/Policy Number: ______________

Employer Name: ______________

Insurance Company Name: __________ Phone: ______

How long have you had this insurance coverage? ______

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.

I authorize release of all information relating to any claims.

I authorize release of all information relating to any claims.