NEW PATIENT REGISTRATION

PLEASE PROVIDE YOUR CHILD AND/OR CHILDREN'S INFORMATION BELOW:

TOTAL NUMBER OF CHILDREN IN FAMILY:_____

NAME:_____SEX:_____DOB:_____

NAME:_____SEX:_____DOB:_____

NAME:_____SEX:_____DOB:_____

NAME:_____SEX:_____DOB:_____

NAME:_____SEX:_____DOB:_____

PLEASE PROVIDE INFORMATION FOR THE RESPONSIBLE PARTY BELOW:

NAME:_____SEX:_____DOB:_____ RELATION:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

CELL:_____ALT PHONE:_____EMAIL:_____

EMPLOYER NAME:_____PHONE:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

IS THERE ANY OTHER PARENT/LEGAL GUARDIAN YOU WOULD LIKE ON THE ACCT? (IF YES, PLEASE COMPLETE)

NAME:_____SEX:_____DOB:_____ RELATION_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

CELL:_____ALT PHONE:_____EMAIL:_____

EMPLOYER NAME:_____PHONE:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

DO YOU HAVE INSURANCE? (circle one) YES NO

IF YES, PLEASE PROVIDE YOUR INSURANCE INFORMATION BELOW:

POLICY HOLDER'S NAME:_____DOB:_____SSN:_____

INSURANCE PROVIDER:_____SUBSCRIBER ID:_____

EMPLOYER:_____GROUP ID:_____

HOW DID YOU HEAR ABOUT US? (select all that apply)

- ☐ **RADIO**
- ☐ **WORD OF MOUTH**
- ☐ **REFERRED BY PHYSICIAN**
- ☐ **COMMUNITY MAGAZINE**
- ☐ **EVENT SPONSOR**
- ☐ **INTERNET/WEB SEARCH**
- ☐ **YELP**

PERMISSION FOR DENTAL SERVICES TO BE PERFORMED ON A MINOR:

I, being the parent (or guardian), of said minor(s) patients to do hereby authorize and request the performance of dental services upon the person of this patient(s) and I hereby authorize the release of x-rays and treatment to an insurance company and/or another dental office.

SIGNED:_____DATE:_____