HARBOR kids' TEETH
SPECIALISTS IN PEDIATRIC DENTISTRY
LISA A. BLOCK, DMD, MS
AARIKA D. ANDERSON ELTER, DMD
WWW.HARBORKIDSTEETH.COM

Today's Date: _____

FAMILY AND CHILD'S REGISTRATION

Father or Guardian:

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Email: _____
Social Security #: _____
Date of Birth: _____
Employer: _____

Mother or Guardian:

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Email: _____
Social Security #: _____
Date of Birth: _____
Employer: _____

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

Your Child's/Children's Name(s)

_____	Age: _____	Birthdate: _____	M ____ F _____
_____	Age: _____	Birthdate: _____	M ____ F _____
_____	Age: _____	Birthdate: _____	M ____ F _____
_____	Age: _____	Birthdate: _____	M ____ F _____

Dental Insurance Carrier:

Carrier: _____
Policy Holder: _____
Group #: _____
ID#: _____
Phone Number: _____

Secondary Dental Insurance Carrier:

Carrier: _____
Policy Holder: _____
Group #: _____
ID#: _____
Phone Number: _____