Patient Registration

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Patient Registration

We are pleased to welcome you and your child to our pediatric dental practice. Our mission is to provide outstanding comprehensive and therapeutic oral healthcare in a friendly environment. A healthy smile starts here!

Patients First Name *

Patients Last Name *

Preferred Name

DOB *

mm/dd/yyyy

Gender *

Siblings

Phone

(___) ___-____

Address

City

State

Please select

Zip Code

_____

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GUARDIAN 1

Relationship to Child *

○ Father ○ Mother ○ Other

First Name

Last Name

Email

Phone Number

(___) ___-____

Address

City

State

Please select

Zip Code

_____

DOB

mm/dd/yyyy

Social Security Number

___-__-____

Employer

Job/Position

GUARDIAN 2

Relationship to Child

○ Father ○ Mother ○ Other

First Name

Last Name

Email

Phone Number

(___) ___-____

Address

City

State

Please select

Zip Code

_____

DOB

mm/dd/yyyy

Social Security Number

___-__-____

Employer

Job/Position

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EMERGENCY CONTACT

Emergency Contact *

Relationship to Patient *

Emergency Phone *

Emergency Contact *

Relationship to Patient *

Emergency Phone *

(___) ___-____

REFERRAL

How did you hear about us? *

○ Dentist ○ Family ○ Pediatrician ○ School ○ Website ○ Other

CHILD'S PRIMARY DENTAL INSURANCE

Policy Holder First Name

Policy Holder Last Name

Relationship to Child

○ Father ○ Mother ○ Self

Insurance Company

Insurance Phone

(___) ___-____

Policy ID #

Policy/Group #

CHILD'S SECONDARY DENTAL INSURANCE

Policy Holder First Name

Policy Holder Last Name

Relationship to Child

○ Father ○ Mother ○ Self

Insurance Company

Insurance Phone

(___) ___-____

Policy ID #

Policy/Group #

To the best of my knowledge, all the information I have provided is true.

Patients First Name *

Patients Last Name *

☐ I am signing on behalf of the patient

Signature *

Today's Date

10/12/2023