— Everyone's — NEW PATIENT REGISTRATION

YOUR CHILD:

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Best Contact Number: _____ Work Phone: _____

Gender: Male Female Marital Status: Married Single Other: _____

Email Address: _____ Yes, send me email alerts

Emergency Contact: _____ Phone: _____

Previous Dentist and/or Dental Office: _____

School Name: _____

Who is responsible for making appointment?

Name: _____ Best time to call: _____Home Phone:_____

Cell Phone:_____ Work Phone:_____Ext:_____

Responsible Party:

Mother: ☐ **Stepmother** ☐ **Guardian** **Father:** ☐ **Stepfather** ☐ **Guardian**

Name of Person Responsible For this Account: _____

Relationship to Patient_____Email:_____

Phone Number: _____Driver's License # _____Date of Birth: _____

Employer:_____ Work Phone: _____ SS#/Sin_____

For your convenience, we off the following methods of payment. Please check the option you prefer. Payment in full required at each appointment. ☐Cash ☐Personal Check ☐Credit Card ☐I wish to discuss the office payment policy

Insurance Information (Policy Holder)

No Dental Insurance Primary Insurance Medicaid Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Date of Birth: _____

Member ID/SS#: _____ Group #: _____

Name of Employer: