CHILD REGISTRATION Date _____

Child's Name (Last) _____ (First) _____ Nickname _____

Age _____ Date of Birth _____

Home Phone _____ School _____

Address _____ City _____ State _____ Zip _____

Father's Name (Last) _____ (First) _____

Father's Date of Birth _____ Daytime Phone _____

Father's E-mail Address _____

Father's Employer _____ Location _____

Social Security Number _____

Dental Insurance Carrier _____ Group Number _____

Dental Insurance Address _____

Phone Number _____

Mother's Name (Last) _____ (First) _____

Mother's Date of Birth _____ Daytime Phone _____

Mother's E-mail Address _____

Mother's Employer _____ Location _____

Social Security Number _____

Dental Insurance Carrier _____ Group Number _____

Dental Insurance Address _____

Phone Number _____

In case of emergency, who should be notified? _____

Relation to Patient _____ Phone Number _____

Whom may we thank for referring you? _____

I understand that I, _____ , the person bringing this child to this dental office, am responsible for payment of all services rendered at this office, including those portions not covered by insurance.

Signature _____ Date _____

Print Form