Welcome to The Kids' Dentist

Date _____

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

School Name/Grade_____

Special Interests/Pets_____

Last Dental Visit_____ /_____ /_____

How did you hear about us?

_____

Whom may we thank for this referral?

_____

Parent's/Guardian's Name_____

How do you wish to be addressed ____

☐ Single ☐ Married ☐ Separated

☐ Separated ☐ Widowed ☐ Minor

Residence – Street_____

City_____ State____ Zip_____

Business Address_____

Telephone: Res._____ Bus._____

Fax_____Cell Phone #_____

Email_____

Patient/Parent Employed By_____

Present Position_____

How Long Held_____

Spouse/Parent Name_____

Spouse Employed by_____

Present Position_____

How Long Held_____

Who is Responsible for this account_____

Driver License No. _____

Method of Payment

☐ Check ☐ Cash ☐ Credit Card

Purpose of Call_____

Other Family Members in this Practice _____

_____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No._____

Someone to notify in case of emergency not living with you _____

DENTAL INSURANCE
1ST COVERAGE

Employee Name_____Date of Birth_____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or policy # _____
Social Security No._____
Union Local or Group_____

DENTAL INSURANCE
2ND COVERAGE

Employee Name_____Date of Birth_____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or policy # _____
Social Security No._____
Union Local or Group_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE

_____

DATE _____

REGISTRATION