MINOR (CHILD) REGISTRATION

PATIENT INFORMATION

First Name: _____ Middle Initial: ___ Last Name: _____

Birth Date: ___/___/___ Social Security #: ____/___/_____ □ Male: □ Female

Name You Would Like Us to Call Your Child: _____

How Did You Hear About Us? _____

MINOR CHILD'S HOME ADDRESS

Street Address: _____ City: _____ State: ____ Zip: ____

Phone #'s Home: (___) _____ Cell: (____) _____

PARENT/LEGAL GUARDIAN CONTACT INFORMATION

Primary: Name: _____ Relationship to Patient: _____

Birth Date: ___/___/___ Social Security #: ____/___/____ Email: _____

Phone #'s Home: (___) _____ Work: (__) _____ Cell: (____) _____

Street Address: _____ City: _____ State: ____ Zip: ____

Secondary: Name: _____ Relationship to Patient: _____

Birth Date: ___/___/___ Social Security #: ____/___/____ Email: _____

Phone #'s Home: (___) _____ Work: (__) _____ Cell: (____) _____

Street Address: _____ City: _____ State: ____ Zip: ____

Emergency Contact: _____ Phone: (___) _____

Relationship to the Patient: _____

Who is Financially Responsible for This Account? _____

PRIMARY INSURANCE

Name of Dental Insurance Company: _____ Group #: _____

Street Address: _____ City: _____ State: ____ Zip: ____

Phone: (___) _____ Employer Name & Address: _____

Subscriber Name: _____ Subscriber ID: _____

Subscriber Birth Date: ___/___/___ Subscriber Social Security #: ____/___/____

SECONDARY INSURANCE

Name of Dental Insurance Company: _____ Group #: _____

Street Address: _____ City: _____ State: ____ Zip: ____

Phone: (___) _____ Employer Name & Address: _____

Subscriber Name: _____ Subscriber ID: _____

Subscriber Birth Date: ___/___/___ Subscriber Social Security #: ____/___/____

_____

Signature of Parent, Legal Guardian **Date**