



Child / Student (up to age 18) Patient Registration

Today's Date _____

Child's Name: _____ Parents' marital status: _____
Last First MI

Parent's/Legal Guardian's Names: _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Address: _____ Child's Date of Birth: _____
Apt # City State Zip

Parent's Email: _____ Child's Age: _____ Male Female

**Please provide a copy, screen shot, or digital photo of your Dental Insurance information.
Or fill out the information below:**

Dental Insurance _____
Company Group # Address

Name of Insurance Policy Holder: _____
Last First MI

Employer _____
Name Address

Date of Birth _____ Age _____ Social Security #: _____

Dental Insurance (Secondary) _____
Company Group # Address

Name of Policy holder: _____

Employer _____
Name Address

How were you referred to this office? Friend or Family (Name) _____
 Community Event Yellow Pages Facebook Walk in Mailer
 Internet site _____ Referred by Dr. _____ Other _____

How will today's services be taken care of? Cash Check Credit Card (MC/Visa)

I certify that the above information is complete and accurate and the information on the Medical History, Dental History, and Sleep Screen Questionnaires.

Signature of Patient, Parent or Guardian

Date

All forms can be submitted electronically via fax, e-mail or digital photo