growing smiles
pediatric dentistry

Registration Form

Tell Us About Your Child

Date: ___/____/____ Child's name:_____Preferred Name: _____

Child's Age: _____ Child's Birthday _____/_____/_____ ☐Male ☐Female Social Security #: _____-_____-_____

School: _____ Grade: _____

Hobbies/Interests: _____

Name of previous dentist/location (if applicable): _____

Child's Home Address: _____City_____State____Zip_____

Child's Home Phone Number:_____

Do the parents and child all live together?: ☐Yes ☐No (Separated parents: **The parent who brings the child is responsible for the account**)

What is the primary reason for today's visit (e.g. pain, checkup, etc.)? _____

_____

General Information

Name of person accompanying the child today:_____ Relationship:_____

Other Siblings?: _____

Name of Relative or Friend not living with you: _____Phone Number: (_____) -_____- _____

Address: _____

Parent's Information

Parent's Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Remarried ☐Partnered

☐Mother ☐Father ☐Step Parent ☐Guardian

Name: _____ DOB:___/___/____

Home# (___)-_____-_____ Cell#: (____)-_____-_____

SSN: _____ DL#:_____

Email:_____

Occupation:_____

Employer: _____

Work#: (____)-_____-_____

☐Mother ☐Father ☐Step Parent ☐Guardian

Name: _____ DOB:___/___/____

Home# (___)-_____-_____ Cell#: (____)-_____-_____

SSN: _____ DL#:_____

Email:_____

Occupation:_____

Employer: _____

Work#: (____)-_____-_____

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Insurance Information

Primary Insurance: Is insurance provided through an employer? ☐ Yes ☐ No If so, please list: _____

Insurance Co. Name: _____Phone #: (_____)- _____

Insurance Co's Address: _____

Subscriber's Name: _____Relationship to patient:_____

Subscriber #: _____Group #: _____

Secondary Insurance: Is insurance provided through an employer? ☐ Yes ☐ No If so, please list: _____

Insurance Co. Name: _____Phone #: (_____)-_____

Subscriber #: _____Group #: _____

Insurance Co's Address: _____

Insured's Name: _____

If you have any questions about this form or are unsure how to answer any questions, we'd be happy to assist you. Please ask!

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment for my child and that providing incorrect information can be dangerous for my child's health. If there is any change in my child's medical status I will inform the dentist. I authorize Growing Smiles Pediatric Dentistry, P.C. to release any information including diagnosis, and the records of any treatment or exam rendered to my child during the period of such dental care, to third party payers and/or their healthcare practitioners.

Signed: _____Date:_____