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:______________