REGISTRATION FOR CHILD

No. ______ ______

Date ______________________

Child's Name ______________________ Birthdate ______________ Sex ❑ M ❑ F

Child's Address ______________________ Phone ______________
Street

____
City Zip

E-Mail ______________________ Cell Phone ______________

Whom May We Thank For Referring You? ______________________

Emergency Name (Other Than Parent) ______________________ Phone ______________

____
Street City Zip

Parent's Marital Status: (Circle One) Single Married Separated Divorced Other

Father's Name ______________________ Birthdate ______________

Father's Employer ______________ Business Address ______________ Phone ______________

Position ______________ Years Employed ______ Father's Soc. Sec. No. ______________

Mother's Name ______________ Birthdate ______ Parent's Dr. Lic. No. ______________

Mother's Employer ______________ Business Address ______________ Phone ______________

Position ______________ Years Employed ______ Mother's Soc. Sec. No. ______________

PERSON RESPONSIBLE FOR THIS ACCOUNT

Father ❑ Mother ❑ Guardian ______________________

Address (If Dif. Than Above) ______________________
Street City

______________________ Years At This Address ______ Phone ______________
State Zip

FOR PATIENTS COVERED BY DENTAL INSURANCE

Subscriber Is: Father ❑ Mother ❑ Guardian ______________________

Insurance Company ______________________ Group No. ______________

(If Covered By More Than One Plan, Fill Out Next Section)

Subscriber Is: Father ❑ Mother ❑ Guardian ______________________

Insurance Company ______________________ Group No. ______________

Deductible ______________ Max Benefit ______________ Benefit Year Starts ______________