ACCT# ______________________

Patient Registration

We are pleased to welcome you and your child to our pediatric dental practice. Our mission is to provide outstanding comprehensive and therapeutic oral healthcare in a friendly environment. A healthy smile starts here!

Last Name ______________________ DOB ____/____/____ ☐ Female ☐ Male

First Name ______________________ Middle Initial ____ Preferred Name ______________________

Address ______________________ City ______________________ State ______

Zip ________ Phone ______________ Siblings ______________________

GUARDIAN 1

Relationship to Child: ☐ Father ☐ Mother ☐ Other

Name ______________________

Address ______________________

City ______________ State ____ Zip ______

Phone ______________________

Email ______________________

DOB ____/____/____ SSN ____-____-____

Employer ______________________

Job/Position ______________________

GUARDIAN 2

Relationship to Child: ☐ Father ☐ Mother ☐ Other

Name ______________________

Address ______________________

City ______________ State ____ Zip ______

Phone ______________________

Email ______________________

DOB ____/____/____ SSN ____-____-____

Employer ______________________

Job/Position ______________________

EMERGENCY CONTACT

Name ______________________ Relationship to Patient ______________ Phone ______________

REFERRAL

How did you hear about us? ☐ Dentist ☐ Family ☐ Pediatrician ☐ School ☐ Website ☐ Other ____________

Whom may we thank for referring you? ______________________

CHILD'S PRIMARY DENTAL INSURANCE

Insurance Co. ______________________

Insurance Phone ______________________

Policy Holder's Name ______________________

Relationship to Child ☐ Father ☐ Mother ☐ Self

Policy ID # ______________________

Policy/Group # ______________________

CHILD'S SECONDARY DENTAL INSURANCE

Insurance Co. ______________________

Insurance Phone ______________________

Policy Holder's Name ______________________

Relationship to Child ☐ Father ☐ Mother ☐ Self

Policy ID # ______________________

Policy/Group # ______________________

treetown
PEDIATRIC DENTISTRY