CHILD REGISTRATION Date ____________________

Child's Name (Last) ________________ (First) ____________ Nickname __________

Age _____ Date of Birth ______________________________

Home Phone ____________ School ______________________________

Address ____________________ City __________ State _____ Zip ____________

Father's Name (Last) ____________________ (First) ________________________

Father's Date of Birth ________ Daytime Phone ______________________________

Father's E-mail Address ______________________________

Father's Employer ______________________________ Location ____________

Social Security Number ________________

Dental Insurance Carrier ________________________ Group Number ____________

Dental Insurance Address ______________________________

Phone Number ________________

Mother's Name (Last) ____________________ (First) ________________________

Mother's Date of Birth ________ Daytime Phone ______________________________

Mother's E-mail Address ______________________________

Mother's Employer ______________________________ Location ____________

Social Security Number ________________

Dental Insurance Carrier ________________________ Group Number ____________

Dental Insurance Address ______________________________

Phone Number ________________

In case of emergency, who should be notified? ______________________________

Relation to Patient ________________ Phone Number ________________

Whom may we thank for referring you? ______________________________

I understand that I, ________________, the person bringing this child to this dental office, am responsible for payment of all services rendered at this office, including those portions not covered by insurance.

Signature ______________________________ Date ________________