COME ORTHODONTICS & PEDIATRIC DENTISTRY

New Patient Registration

Welcome to our office! Please take a few minutes to fill out this form as completely as you can.

Child's Name: _____ Today's Date: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ [ ] Male [ ] Female

Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Who schedules appointments? _____ Parent's Marital Status: [ ] M [ ] S [ ] Sep [ ] D [ ] W

Siblings names & ages: _____ How did you hear about us? _____

Parent 1 Information:

[ ] Mother [ ] Father [ ] Step Mother [ ] Step Father [ ] Legal Guardian [ ] Other: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security: _____-____-_____ Occupation: _____

Home Address: [ ] Same as child's _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Preferred method of contact: _____

Is this parent legally responsible for the health care decisions of the above patient? [ ] Yes [ ] No

Parent 2 Information:

[ ] Mother [ ] Father [ ] Step Mother [ ] Step Father [ ] Legal Guardian [ ] Other: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security: _____-____-_____ Occupation: _____

Home Address: [ ] Same as child's _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Preferred method of contact: _____

Is this parent legally responsible for the health care decisions of the above patient? [ ] Yes [ ] No

In a medical emergency where neither of the above individuals can be reached, who else may we contact?

Name: _____ Relationship: _____ Phone: _____

Dental Insurance Information (if applicable)

Insurance Company Name: _____ Ins. Co. Phone: _____

Group Number: _____ Policy Number: _____

Who is the primary person on this policy? _____ SSN: [ ] above____-____-____

Employer of person insured: _____ DOB of insured: [ ] above _____

Do you have secondary insurance? [ ] Yes [ ] No

Secondary Insurance Co. Name: _____ Ins. Co. Phone: _____

Group Number: _____ Policy Number: _____

Who is the primary person on this policy? _____ SSN: [ ] above____-____-____

Employer of person insured: _____ DOB of insured: [ ] above _____

_____

Signature of parent / guardian (or patient if over 18 years of age) Relationship to patient Date