



### Family Registration

Welcome to our office. Please complete this registration form. If you have any question, please ask.

Today's Date \_\_\_\_\_ Who may we thank for referring our office? \_\_\_\_\_

#### Please Tell Us About Yourself (Parent or Guardian)

We will list your name as head of the account for financial responsibility and treatment plan authorization.

Your Name  Mr.  Mrs.  Ms.  Miss  Dr. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name Last Name Month / Date / Year

Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) Cell or Work Phone ( )

#### About the Other Parent or Guardian

Their Name  Mr.  Mrs.  Ms.  Miss  Dr. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name Last Name Month / Date / Year

Address  Same \_\_\_\_\_  
Street City State Zip

Home Phone ( ) Cell or Work Phone ( )

#### About Your Child

Child's Name  Boy  Girl \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name Last Name Month / Date / Year

Address  Same \_\_\_\_\_  
Street City State Zip

Home Phone ( ) Additional Phone ( )

#### Financial Information

Payment at time of service is expected unless financial arrangements are made with our receptionist. We accept payment in cash, checks, or credit cards (VISA, MasterCard, Discover). We have the same prices for our services regardless of insurance coverage. We can file insurance claims for you, and accept assignment of payment to our office. We ask the following information from you if you want us to file insurance claims. We use HIPPA privacy rules to secure your data. If your insurance information on file with us is current, and you are registering another child, please tell the receptionist and we will use that information.

#### Insurance Registration

Please remember that you have the financial responsibility for your child's account, regardless of the level of coverage with your insurance company.

Please refer to our office brochure for payment policy details. If you have two insurance coverages, please use a second page and indicate which one is primary and which one is secondary.

If you have any questions, please ask our receptionist. Thank you.

#### Adult Who Has the Insurance for the Child

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name Last Name Month / Date / Year

Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) Insurance ID or Social Security Number \_\_\_\_\_

Employer's Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone ( ) Fax Number ( )

Plan Name \_\_\_\_\_ Group Number \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Electronic Payer ID Number \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone ( ) Fax Number ( )