



Family Registration

Welcome to our office. Please complete this registration form. If you have any questions, 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 () Cell () Work ()

Email _____ Primary Phone for Office to Contact Home Cell Work
An Email will be Sent to Confirm Appointments

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 () Cell () Work ()

Email _____ Primary Phone for Office to Contact Home Cell Work

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 Dental Insurance for the Child (fields in bold print are required)

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 ()