Smiles for Kids Pediatric Dentistry
Patient Registration Form

Patient's Last name_______________________ **First name**___________________________
Nickname_____________________ Birthdate____________________ Sex: M F
Address______________________________ School_________________________
______________________________ Grade__________

Responsible Party

With whom does patient live?___________ Person responsible for account___________________
Who brought patient today?_____________ Does patient have dental insurance?_______

Parent or Guardian Information

Mother Stepmother Guardian
Name______________________________ SSN________________ Birthdate________________
Address___________________________________ Driver's license no.________________________
___________________________________ Employer_________________________________
Phone: Mobile_____________________________ Title______________________________________
Home______________________________ Work phone______________________________

Father Stepfather Guardian
Name______________________________ SSN__________________ Birthdate__________________
Address___________________________________ Driver's license no.________________________
___________________________________ Employer_________________________________
Phone: Mobile_____________________________ Title______________________________________
Home______________________________ Work phone______________________________

Primary Insurance Carrier______________________ Name of insured_____________________________
Contract no._________________________________ Group no._______________________________

Whom may we thank for referring you to our office?_________________________

I have reviewed the information on this form and it is accurate to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist insurance benefits. Furthermore, I understand that, even though I may have dental insurance, I am responsible for all financial obligations that may arise as a result of any dental treatment provided for my child.

Signature of Parent/Guardian

X______________________________________
Date_________________________