

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 _____ Date of Birth _____ SS# _____
First Name Last Name Month/Date/Year

Address _____ Marital Status _____
Street City State Zip

Home Phone (_____) _____ Cell or Work Phone (_____) _____

About the Other Parent or Guardian

Their name _____ Date of Birth _____
First Name Last Name Month/Date/Year

Address _____ Marital Status _____
Street City State Zip

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

About Your Child

Child's name _____ Date of Birth _____
First Name Last Name Month/Date/Year

Address _____ Social Security # _____
Street City State Zip

Home Phone (_____) _____ Additional Phone (_____) _____

Financial Information

Payment at the time of service is expected. We accept payment in cash, checks, or credit card (Visa, MasterCard and Discover). We also offer a financing option through CareCredit. 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 HIPAA privacy rules to secure your data. If your insurance information on file with us is current, and you are registering another child, please tell our receptionist and we will use that information.

Financial Information

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 financial policy for more details. If you have two insurance coverages, please list your primary insurance on this page.

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 _____ Home Phone (_____) _____
Street City State Zip

Insurance ID or SS# _____ Employer's Name _____

Employer's Address _____ Phone (_____) _____ Fax (_____) _____

Plan Name _____ Group Number _____

Dental Insurance Co. _____ Electronic Payer ID # _____

Address _____ Phone (_____) _____ Fax (_____) _____