Welcome to Pediatric Dentistry of Greenwood

Jennifer B. Turner, D.M.D.

Board Certified Pediatric Dentist

Patient Registration

Today's Date: ____________________

1. Tell Us About Your Child

Child's Name____
Last First MI

Goes by ____________________ ___ Male ___ Female

Siblings that we treat: ______________________________

Child's Birthdate: ___/___/___ **Age**: ___ Weight: ____

School: ________________________ Grade: _________

2. Whom may we thank for referring you to our office?

____

3. Mother's Information

Name ____

Mother / Stepmother / Guardian Birthdate: __________

Home Address: ___________________________________

E-mail Address: _______________________________

Home # (____)__________ Cell # (____)__________

Work # (____)__________ Occupation: ___________

Employer: ______________________________________

SS # : _____________ Mother's Dentist: ___________

4. Father's Information

Name ____

Father / Stepfather / Guardian Birthdate: ___________

Home Address: ___________________________________

E-mail Address: _________________________________

Home # (____)__________ Cell # (____)__________

Work # (____)_________ Occupation: _____________

Employer:_______________________________________

SS # : _____________ Father's Dentist: ____________

5. Who is Accompanying the Child Today?

Name ____

Relationship ___________________________________

Are you this child's legal guardian? Yes No

6. Family Information

Child's parent's are: ___ Married ___ Divorced

___ Separated ___ Not Married

If the parent's do not live together, with whom does the child live? ______________________________

7. Person Responsible for Account

Name ____

Relationship to patient ___________________________

Billing Address ________________________________

____

Cell # (____) __________ Work # (____) __________

8. Primary Dental Insurance

Insurance Co. Name _____________________________

Group Number (Policy #) _________________________

Insurance Co. Address ___________________________

Insurance Co. Phone # (____)______________________

Policy Owner's Name _____________________________

Policy Owner's Birthdate ___________ SS# _________

9. ___ My child does not have Medicaid Coverage, nor have I applied with the Medicaid Program for my child's dental insurance.

10. The payment of fees for professional services provided is expected at the time of treatment by the parent or guardian in attendance. We accept payment in cash, checks or credit card (Visa, Mastercard and Discover). We also offer financing options through Care Credit. We charge the same fees for our services regardless of insurance coverage. We can file insurance claims for you, and accept assignment of payment to our office. We ask that you provide the above insurance information if you want us to file insurance claims. We use HIPPA privacy rules to secure your data.

My signature on this document authorizes the doctors of this practice to submit claims for benefits for services rendered. I also understand that balances remaining over 90 days from billing may be sent to a collection agency, and I agree to pay all collection costs if this occurs.

Signature of Parent or Legal Guardian ______________________________ Date ____________________