Patient Registration

(Please fill out one per family)

Child's First and Last Name: ______________________________________ Date of Birth: _________________

Child's Preferred Name: ____ Gender: Male Female

Child's Address: ____

Child's City, Zip Code: ____

Additional Children's Names on Same Account:

(2)______________________________ Male Female DOB: _________________ Preferred Name: _______________

(3)______________________________ Male Female DOB: _________________ Preferred Name: _______________

(4) ______________________________ Male Female DOB: _________________ Preferred Name: _______________

Mother's Full Name: ______________________________ Date of Birth: ______________ Occupation: ________________

Father's Full Name: ________________________________ Date of Birth: ______________ Occupation: ________________

Parents Relationship: ◯ Married ◯ Partnered ◯ Single ◯ Divorced/Separated ◯ Widowed

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RESPONSIBLE PARTY: (Person Financially Responsible for Account)

Responsible party is (please circle): ◯ Mother ◯ Father ◯ Other ___________________

Full name (if not listed above): ____

Address (if different than above): ____

City, State, Zip Code: ____

CONTACT INFORMATION:

Email Address:____

Home Phone: __________________ Work Phone: _____________________ Cell Phone: ______________________

Which number would you prefer we call for appointment confirmation: ◯ Home ◯ Work ◯ Cell Phone

Insurance/Family Information

(Please fill out one per family)

Child's Name:________________________________ Today's Date: ____________

Primary Dental Insurance Information

Policy holder: ◯ Mother ◯ Father ◯ Other ◯ My child does not have dental insurance

Employer's Name: ___________________________________
Insurance's Name and State: _____________________________
Insurance's Phone Number: _______________________
ID #:_____________________________ Social Security number # _____________________
Group #:__________________________

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Secondary Dental Insurance Information (if applicable)

◯ My child does not have any secondary dental insurance

Policy holder: ◯ Mother ◯ Father ◯ Other
Employer's Name: ___________________________________
Insurance's Name and State: _____________________________
Insurance's Phone Number: _____________________________
ID #:_____________________________ Social Security Number # _____________________
Group #:__________________________

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How did you hear about The Kids Dentist?

◯ Pediatrician ◯ Dentist ◯ Friend ◯ Advertisement ◯ Insurance Company
◯ Google ◯ Facebook ◯ Other:________________

***Please provide us with the name of your referral source so we may thank them: ________________________

What type of water do you use?

◯ Municipal Tap Water ◯ Filtered Water (Brita, refrigerator/etc.)
◯ Bottled Water ◯ Well Water
◯ Yes ◯ No Have you had your well tested?
◯ Yes ◯ No Do you have a reverse osmosis filtration system?

Is there a family history of any of the following:

◯ Missing Teeth ◯ Dental Decay ◯ Under/Over Bite ◯ Jaw Surgery
◯ Extra Teeth ◯ Gum Disease ◯ Other:_______________________

Has anyone in your family had any difficulty with dental care/visits in the past? ◯ Yes ◯ No