



**PATIENT REGISTRATION (Child/Adolescent)**

**Patient Name:** \_\_\_\_\_

Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Male  Female Age: \_\_\_\_\_ Nickname: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security# \_\_\_\_\_

Minor Living With:

Both Natural Parents  Natural Mother  Natural Father  Other \_\_\_\_\_

School Attending: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ AGE: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security# \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone # : \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ AGE: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security# \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone # : \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In case of emergency, please notify my nearest relative or acquaintance not living with me.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Dental Insurance Primary Carrier**

Insurance Company: \_\_\_\_\_

Employee: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Group No.: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

**Dental Insurance Secondary Carrier**

Insurance Company: \_\_\_\_\_

Employee: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Group No.: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_