THOMASVILLE Pediatric Dentistry

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PATIENT REGISTRATION FORM

TELL US ABOUT YOUR CHILD

Child's name_____ Nickname_____ ☐Male ☐Female
Child's birthdate_____ Child's age_____ School_____ Grade_____
Child's home address_____ City_____ State_____ Zip_____
Child's home number_____ Social Security #_____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name_____ Relation_____ Do you have legal custody of the child? ☐Yes ☐No
Emergency Contact "not living at same address" (name & telephone) _____
Whom may we thank for this referral?_____

PERSON RESPONSIBLE FOR ACCOUNT

Mother's Information

Name _____ Date of birth _____
Address _____ For how long?_____
_____
Employed by _____ For how long?_____
Occupation _____
SS# _____
Driver's license # _____
Business phone _____
Home phone _____
Cell phone_____

Father's Information

Name _____ Date of birth _____
Address _____ For how long?_____
_____
Employed by _____ For how long?_____
Occupation _____
SS# _____
Driver's license # _____
Business phone _____
Home phone _____
Cell phone_____

DENTAL INSURANCE COMPANY

Only primary insurance will be filed

Insurance Co. name _____
Insurance Co. address _____
Insurance Co. phone _____ Group # (plan, local, or policy #)_____
Insured's name _____ Relationship to child _____
Insured's birthdate_____ ID # _____ Insured's employer_____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Johnson, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

_____
Signature **Date**