CHILD REGISTRATION

DENTAL ASSOCIATES

Date:____/____/____

Patient: _____

*Address:*_____ *City:*_____ *St:*____ *Zip:* _____

*Daytime Phone: (____)*_____ *Work Phone: (____)*_____

*Child's Social Security #:*_____ *Full-time Student:* ____ *Yes* ____ *No*

Birth Date: ____/____/____ *School:* _____

Mother's Name: _____ *SS#* _____ *Birth Date:* __/__/__

*Address:*_____ *City:*_____ *St:*____ *Zip:* _____

*Home Phone: (____)*_____ *Work Phone: (____)*_____

*Employer:*_____ *Position:* _____

*Business Address:*_____ *City:*_____ *St:*____ *ZIP:* _____

Father's Name: _____ *SS#* _____ *Birth Date:* __/__/__

*Address:*_____ *City:*_____ *St:*____ *Zip:* _____

*Home Phone: (____)*_____ *Work Phone: (____)* _____

*Employer:*_____ *Position:* _____

*Business Address:*_____ *City:*_____ *St:*____ *Zip:* _____

Person Responsible for the Account: _____

*Birth Date:*____/____/____ *SS#:*_____

*Address:*_____ *City:*_____ *St:*____ *Zip:* _____

*Home Phone: (____)*_____ *Work Phone: (____)* _____

*Employer:*_____ *Position:* _____

*Business Address:*_____ *City:*_____ *St:*____ *Zip:* _____

Bank & Branch:_____ **Account No:**_____

Primary Dental Insurance Co: _____

*Employee:*_____ *Group Name:*_____

*Group #:*_____ *Union/Local #:* _____

Secondary Dental Insurance Co: _____

*Employee:*_____ *Group Name:*_____

*Group #:*_____ *Union/Local#:* _____

Who May We Thank For Referring You? _____

I authorize the release of any information regarding dental treatment. I understand that I am responsible for all fees incurred. I authorize insurance payment to be paid directly to Dental Associates. I understand that where approriate, credit bureau reports may be obtained.

Signature:_____ **Date:** _____