



## CHILD REGISTRATION FORM

*This information is requested so that we may provide you the most comprehensive care possible. It is important to have complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank you.*

**Patient** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Father's SS # \_\_\_\_\_ Father's DOB \_\_\_\_\_

Father's Employer \_\_\_\_\_

Mother's Name \_\_\_\_\_ Mother's SS # \_\_\_\_\_ Mother's DOB \_\_\_\_\_

Mother's Employer \_\_\_\_\_

E-mail \_\_\_\_\_  I would like to receive correspondences via e-mail

Is your child experiencing any dental problems at this time? If so, please describe \_\_\_\_\_

When was your child's last dental visit? \_\_\_\_\_ What was done then? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Is your child covered by dental insurance? \_\_\_\_\_

**Primary Insurance Information:** Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Name of Insured \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child  Other \_\_\_\_\_

**Secondary Insurance Information:** Name of Insurance Company \_\_\_\_\_

Name of Insured \_\_\_\_\_ SS # \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name, Address & Phone \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child  Other \_\_\_\_\_

*I hereby authorize and request the performance of dental services for \_\_\_\_\_, age \_\_\_\_\_ by Dr. Alison Gomes and staff. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Gomes and staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage.*

\_\_\_\_\_  
 (Signature of Responsible Party)                      (Relationship to Child)                      (Date)