CHILD NEW PATIENT REGISTRATION

919-859-1000 | email to: team@dentistrybydesignofcary.com

1. CHILD PATIENT INFORMATION

- Today's date: ______________
- Child's name: ______________________________
- Preferred name: ____________________________
- Date of birth: ___________________
- Social security #: _______________
- Grade: _______ School attended:___________________________________

2. PARENT OR LEGAL GUARDIAN INFORMATION (Choose one person that will usually bring the child)

- Parent or Legal Guardians name: ______________________________
- Preferred name: ____________________________
- Date of birth: ___________________
- Social security #: _______________
- Address: ____
- City: ____________________ State: ____ Zip: ________
- Cell #: ___________ Home #: ___________ Work #: ___________
- E-mail: ____
- Best way to contact you: ___________________________
- Marital status. Please check one:

  Single Married Separated Divorced Widowed

- Name of employer: _____________________________________
- Your occupation: ____
- How did you find our practice? ____________________________
- Name of emergency contact: _________________
- Relationship to patient: _____________ Phone #: ________________

3. DENTAL INSURANCE

Choose one of the following options which apply to you

I have dental insurance for my child. **COMPLETE THIS SECTION**

OR

I do not have dental insurance for my child. **SKIP THIS SECTION AND MOVE TO SECTION 5**

- Name of insurance company: ___________________________________
- Telephone #: ____________________
- Subscriber/Member ID #: ____________________
- Group #: ______________________
- Claims mailing address: ____________________________
- City: ____________________ State: _____ Zip: ______

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4. SUBSCRIBER (The person who owns the dental insurance policy)

Choose one of the following options which apply to you.

I am not the subscriber for my child's dental insurance. **COMPLETE THIS SECTION**

OR

I am the subscriber for my child's dental insurance. **SKIP THIS SECTION AND MOVE TO SECTION 5**

- Name of the subscriber: _______________ Date of birth: _________
- Social security #: _____________________
- Relationship to the patient: ________________________
- Address: ____
- City: _____________________ State: _____ Zip: ______
- Best phone # to be contacted at: ____________________________
- Name of employer: ____
- Occupation: ____
- Work phone #: ____________________________

5. NAME ON ACCOUNT AND RELATIONSHIP

Choose one of the following options which apply to you.

I want my child's statements sent to me, I will be the name on the account.

OR

I have other family members coming here and want to be on their account.

I want my child's statements sent to the name on this account

- Name on the Account: _______________________
- Relationship to the patient: ___________________________

I understand that I am responsible to inform this office of any changes to the information I have provided on this form prior to any appointment in order to prevent any delay in processing claims and statements.

Printed Name: _____________________________________

If other than patient, indicate relationship to patient: _____________________________________

Date: ______________ Signature:____

Date: ______________ Witness:____