

Pediatric Dental Arts

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Date:Patie	ent Registration	Chart ID#:
First Name: Middle Initial Nickname: Date of Birth: School: Is this your child's first dental visit? Y N If no, no Date of last visit: Purpose: Has your child had any bad past dental experiences? Y Have any other children in your family been a patient in the Name(s) and age(s) of sibling(s): Child's Favorite Interests: Name of Parent's Dentist: Who may we thank for referring you to our office?	Grade: Is this are ame of former dentist Reason for today's visit: \[\Boxedom N Please explain: \text{is office before?} \Boxedom Y \Boxedom N	n emergency visit?
Gener	al Information	
Parent/Guardian Full Name: Date of Birth: Address: City: State: Cell Phone #: E-Mail: Occupation: Employer: Child lives with both parents one parent I understand that overdue balances Signature of Parent/Guardian For Patients Cove	Date of Birth: Address: City: Home #: Cell Phone #: E-Mail: Occupation: Employer: nt oth	State: Zip Code:
PRIMARY DENTAL INSURANCE COMPANY Dental Ins. Co.: Subscriber ID/SSN#: Group/Policy#: This Dental Insurance is provided through (Subscriber Name: Relationship: Date of Birth: Employer: In order to comply with most insurance companies, we as	Subscriber ID/SSN#: Group/Policy #: r): This Dental Insurance Name: Relationship: Date of Birth: Employer:	is provided through (Subscriber):
I authorize release of any information relating to this claim.		nt directly to the above-named dentists of benefits otherwise payable to me.