Smiles for the Future Pediatric Dentistry & Orthodontics
Registration Form

CHILD/PATIENT'S NAME: _____ **NICKNAME:** _____ **M / F** **DOB:** _____
FIRST AND LAST

CHILD/PATIENT'S LEGAL ADDRESS:

_____ _____
STREET TOWN ZIP CODE

CHILD LIVES WITH: _____**RELATIONSHIP:**_____**PHONE:**_____

MOTHER'S Information (or legal caretaker)

NAME: _____
FIRST AND LAST

MARRIED, DIVORCED, SINGLE, SEPARATED

DOMESTIC PARTNERSHIP

EMPLOYER:_____

OCCUPATION _____

PHONE: (____)_____(____)_____
WORK CELL

DOB: _____

FATHER'S information (or legal caretaker)

NAME: _____
FIRST AND LAST

MARRIED, DIVORCED, SINGLE, SEPARATED

DOMESTIC PARTNERSHIP

EMPLOYER:_____

OCCUPATION _____

PHONE#:(____)_____(____)_____
WORK CELL

DOB: _____

BROTHERS & SISTERS: _____
FIRST & LAST NAMES AND DOB EMERGENCY

CONTACT OTHER THAN PARENTS: _____**(_____)**_____
NAME PHONE RELATIONSHIP

HOW DID YOU HEAR ABOUT US?_____

☐ **PATIENT DOES NOT HAVE DENTAL INSURANCE (PAYMENT IS EXPECTED AT TIME OF SERVICE)**

PRIMARY DENTAL INSURANCE(copy of card required)

INSURED'S NAME_____

RELATIONSHIP_____

INSURANCE CO_____

POLICY ID#_____GROUP #_____

PHONE_____EFFECTIVE DATE _____

INSURANCE ADDRESS_____

CITY_____STATE_____ZIP_____

ADDITIONAL DENTAL INSURANCE (copy of card required)

INSURED'S NAME_____

RELATIONSHIP_____

INSURANCE CO _____

POLICY ID#_____GROUP#_____

PHONE_____EFFECTIVE DATE_____

INS ADDRESS _____

CITY_____STATE_____ZIP_____

I hereby authorize Smiles for the Future Pediatric Dentistry and Orthodontics to submit a claim in an effort to obtain payment from my insurance carrier(s) for services rendered. I understand that the financial responsibility remains with me regardless of coverage.

Signature: _____ **Date**_____