



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)

FATHER'S information (or legal caretaker)

NAME: _____
FIRST AND LAST

NAME: _____
FIRST AND LAST

MARRIED, DIVORCED, SINGLE, SEPARATED

MARRIED, DIVORCED, SINGLE, SEPARATED

DOMESTIC PARTNERSHIP

DOMESTIC PARTNERSHIP

EMPLOYER: _____

EMPLOYER: _____

OCCUPATION _____

OCCUPATION _____

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

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

DOB: _____

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)

ADDITIONAL DENTAL INSURANCE (copy of card required)

INSURED'S NAME _____

INSURED'S NAME _____

RELATIONSHIP _____

RELATIONSHIP _____

INSURANCE CO _____

INSURANCE CO _____

POLICY ID# _____ GROUP # _____

POLICY ID# _____ GROUP# _____

PHONE _____ EFFECTIVE DATE _____

PHONE _____ EFFECTIVE DATE _____

INSURANCE ADDRESS _____

INS ADDRESS _____

CITY _____ STATE _____ ZIP _____

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 _____