Preference Dental

CHILD REGISTRATION FORM

Today's Date _____ **Dr.** _____

Child's Name _____ **Nickname** _____ **Birth date** _____

Street Address _____ **City** _____ **State** ___ **Zip** _____

Home Phone (___) _____ **School** _____ **Grade** _____
Email address_____
Whom may we thank for referring you to our office? _____

Has your child had any illnesses other than normal childhood illnesses? Yes ___ No ___
Please explain_____
Is your child currently taking any medications? Yes ___ No ___
LIST: _____
Is your child allergic to any medications? Yes ___ No ___
LIST: _____
Has your child ever been treated with antibiotics? Yes ___ No ___
Is this your child's first visit to the dentist? Yes ___ No ___
Has your child complained of any dental pain? Yes ___ No ___
Please explain_____
Who brushes your child's teeth? _____ How often? _____
Is your child currently taking fluoride vitamins Yes ___ No ___
What is your child's attitude toward dental care? Circle one.
Cheerful Neutral Fearful Hostile
What is your child's favorite sport, toy or hobby? _____ _____

Father's Name _____ Phone (___) _____
Address (if different than above) _____
Mother's Name _____ Phone (___) _____
Address (if different than above) _____

Dental Insurance Information: Members Name _____
Social Security Number _____ Date of Birth _____
Employer _____ Group Number _____ Type of Insurance _____

Person Responsible for Payment
Name _____ Relationship to Child _____ Phone (___)_____
Address _____
Social Security Number_____ __ Drivers License _____

FINANCIAL RESPONSIBILITY:
This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including all attorney fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 30% or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.
INSURANCE COVERAGE IS ESTIMATED. WE WILL SUBMIT TO ALL DENTAL INSURANCES AS A COURTESY. YOU THE PATIENT ARE RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY YOUR INSURANCE CARRIER.

Date: _____ **Signature**: _____