ALL SMILES
ORTHODONTICS & CHILDREN'S DENTISTRY

PATIENT REGISTRATION FORM

CONTACT INFORMATION

Home Address	
Home Telephone	

PATIENT INFORMATION

Child 1	First Name:	Last Name:	Nick Name:
	Age:	Birthday: / /	Gender: ☐ Boy ☐ Girl
Child 2	First Name:	Last Name:	Nick Name:
	Age:	Birthday: / /	Gender: ☐ Boy ☐ Girl
Child 3	First Name:	Last Name:	Nick Name:
	Age:	Birthday: / /	Gender: ☐ Boy ☐ Girl

PARENT INFORMATION

FATHER	MOTHER
Name:	Name:
Birth Date: / /	Birth Date: / /
Occupation:	Occupation:
Employer:	Employer:
Business Phone:	Business Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Preferred Contact Method:	

INSURANCE INFORMATION

PRIMARY COVERAGE		SECONDARY COVERAGE (IF APPLICABLE)	
Subscriber Name:		Subscriber Name:	
Home Address:		Home Address:	
Social Security:		Social Security:	
Insurance Carrier		Insurance Carrier	
Group Name:	Group #:	Group Name:	Group #:

MISCELLANEOUS

Whom may we thank for referring you to our office?

I authorize routine dental procedures for my child. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and diagnostic x-rays considered necessary by the dentist for the comfort, health, and well being of my child.

Legal Guardian (Print): _____

Legal Guardian Signature: _____ Date: _____