CHILD REGISTRATION & MEDICAL HISTORY

(please print)

Date______________ Home Phone__________________

Patient____
Last name First M.I. Preferred name

Street Address__________________________City__________________State________________ Zip___________

Child D.L.# (if applicable)______________________Child Social Security # __________________________

Sex_________Age______Birth date________________Grade___________School___________________________

Father's name___________________________Birth date___________Social Security #_________________

Address if different from above____
Street City State Zip Code

Employer____Wk Address______________________________

Father's Occupation _________________________________Wk Phone _______________D.L. #____________

Father's Mobil/Pager#____________________________ E-mail ____________________________________

Mother's name___________________________Birth date___________Social Security # _________________

Address if different from above____
Street City State Zip Code

Employer____Wk Address______________________________

Mother's Occupation _________________________________Wk #___________________D.L. #____________

Mother's Mobil/Pager#____________________________ E-mail ____________________________________

Person financially responsible ______________________________________Relation _________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

In case of emergency notify ______________________________________Relation____________________

Address___________________________City ____________________State_____________Zip Code___________

Home # ___________________________ Work #______________________________

Nearest relative not living with you_________________________________Relation____________________

Address___________________________City____________________State ____________Zip Code ___________

Home # ___________________________ Work #______________________________

DENTAL INSURANCE INFORMATION

Name of policy holder____________________________ Social Security # ________________________

Name of Group Plan____________________________ Union or Group # ________________________

Mailing Address of Insurance Co. (Name, street, address, and/or P.O. Box, City, State and Zip Code____________
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Phone #_______________________________________