Natural Smiles Dental Care

*Child Registration

4700 Lexington Ave, Suite D
contact@naturalsmilesdental.com

*Today's Date:*_____

Patient name:_____
*Nickname preferred:*_____
*Birthdate:*_____ *Male* ___ *Female*___
*School:*_____
*Home address:*_____
*Phone:*_____
*Mom Cell #:*_____ *Work #:*_____
*Dad Cell #*_____ *Work #:*_____

*Contact Email:*_____

*Who has legal custody of the child?*_____

*How did you hear about us?*_____

*Previous DDS:*_____
Person responsible for Account:
_____

*Parents' names:*_____
*Is the child covered by insurance?*_____
If yes, please fill out next column >

*Dental coverage? Yes*_____ *No*_____
*Insurance Company:*_____
*Insured's Name:*_____
*Insured's Birthdate:*_____
*Insured's ID #*_____
Group # _____
*Insured's Employer:*_____

*Any 2nd Insurance coverage? Yes*___ *No* ___
*Insurance Company:*_____
*Insured's Name:*_____
*Insured's Birthdate:*_____
*Insured's ID#*_____
*Group #:*_____
*Insured's Employer:*_____

Payment is due in full at time of treatment. I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment and deductibles estimates at each appointment that insurance does not cover. I hereby authorize payment directly to Natural Smiles Dental Care otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination to my insurance company.

Signature *Date*

_____ _____