Angel Smiles Pediatric Dentistry

Patient Registration

We are pleased to welcome you to our office. Please take a few minutes to fill out this Form as completely as you can. If you have any questions we'll be glad to help you.

YOUR CHILD'S INFORMATION

Your Child's Name _____
Last First MI (Preferred)

Birthdate _____ SS#_____ Gender: ☐ M ☐ F

Child's Home Address_____

City_____ State_____ Zip _____Home phone _____

Email_____School/Grade_____

Other Family members seen by us:

Brothers (Name and Birthdate): _____

_____

Sisters (Name and Birthdate): _____

_____

How did you hear about us? ☐ From another patient, friend/relative:_____

☐ Newspaper/Ads: _____ ☐ Websites_____ ☐ Dental office_____

☐ School_____ ☐ Other _____

(If someone referred you here, please write down their name so we can thank them.)

RESPONSIBLE PARTY

Mother's/Guardian's Information:

Name _____
Last First MI (Preferred)

Birthdate _____SS #:_____Email Address _____

Work Phone _____Cell Phone_____ Text Messaging ☐ Yes, ☐ No

Employer _____ Occupation: _____

Address/Home Phone (if different) _____

Father's/Guardian's Information:

Name _____
Last First MI (Preferred)

Birthdate _____SS #_____ Email Address _____

Work Phone_____Cell Phone_____ Text Messaging ☐ Yes, ☐ No

Employer_____ Occupation: _____

Address/Home Phone (if different) _____

INSURANCE POLICY 1

Subscriber Name _____Subscriber ID # or S.S. # _____

Subscriber Birthdate _____ Relationship to Patient: ☐ Self ☐ Parent

Insurance Company _____ Phone # _____

Employer _____Group Name_____ Group # _____

INSURANCE POLICY 2

Subscriber Name _____Subscriber ID # or S.S. #_____

Subscriber Birthdate _____ Relationship to Patient: ☐ Self ☐ Parent

Insurance Company _____ Phone # _____

Employer _____Group Name_____ Group # _____