

## PATIENT REGISTRATION

CHILD'S LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_  
NICKNAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  MALE  FEMALE  
MOTHER'S NAME: \_\_\_\_\_ HOME TELEPHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
EMPLOYED BY: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
FATHER'S NAME: \_\_\_\_\_ HOME TELEPHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
EMPLOYED BY: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_  
PRIMARY INSURANCE NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
MAILING ADDRESS FOR CLAIMS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
EMPLOYER NAME FOR DENTAL INSURANCE: \_\_\_\_\_

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## FINANCIAL AGREEMENT

I will be responsible for any financial obligations incurred in connection with dental treatment rendered on behalf of my child. I understand that payment must be paid at the time services are rendered. I further understand that I am responsible for any charges incurred which are not covered by my dental insurance.

Please provide 24 hours prior notice to cancel or reschedule an appointment. We charge appointment fees for any missed appointments in the event adequate notice is not provided.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

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## PERMISSION FOR TREATMENT UPON A MINOR

I, being the parent or legal guardian of the above minor patient, hereby authorize and request the performances of dental services for this patient; and further, the performance of whatever procedures the judgment of the named doctor may consider necessary during the performance of any operation. In addition I also authorize the administration of whatever anesthetics or analgesics which the doctor deems advisable during the rendering of care.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_  
DENTIST SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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## HIPAA ACKNOWLEDGMENT

I acknowledge that I have received a copy of The Children's Dental Zone *Notice of Private Practices* and understand I have a right to review prior to signing this document. *You may refuse to sign this part of the document.*

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_  
PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_