

Welcome to our office!

Minor Registration Form

Child's Name _____ Phone _____
Last First Middle

Mailing Address _____ Birthday _____ Age _____

Residence _____

If Injury: Date _____ Where injury took place _____

Referred to us by _____ Phone _____

Person Responsible for Account _____

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Mother/Guardian _____
Last First Middle

Social Security # _____ Birthdate _____

Marital Status: Married Separated Divorced Single Widowed

Address _____ Home phone _____

Present Employer _____ Work Phone _____

Address _____ Occupation _____

Dental Insurance Co _____ Years There _____

Group No/Local _____ Pharmacy you use _____

Please present insurance card if available
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Father/Guardian _____
Last First Middle

Social Security # _____ Birthdate _____

Marital Status: Married Separated Divorced Single Widowed

Address _____ Home phone _____

Present Employer _____ Work Phone _____

Address _____ Occupation _____

Dental Insurance Co _____ Years There _____

Group No/Local _____ Pharmacy you use _____

Please present insurance card if available
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Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (10% APR) may be added to my account.

Parent/Guardian _____ Date _____

Relationship to Patient _____