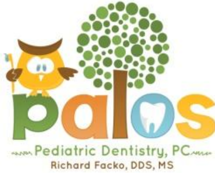

New Patient Registration

Palos Pediatric Dentistry, PC

Child's Name: ____
Last First MI

Child's Preferred Name: _______________________ ☐ Male ☐ Female

Child's SSN: _____________________ Child's DOB: ________

Your Name: ____
Last First MI

Address: ____________________________City _______________ State ___ ZIP________

Home Phone: ______________Work Phone: ________________Cell Phone:________________

E-mail Address: ___________________ Preferred contact method (circle): phone / text / email

Employer: _______________________________ Occupation:_________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you hear about our office?____

Insurance – Primary

Subscriber Name: _________________Relationship to Patient: ________ Subscriber DOB: ________

Subscriber SSN/ID: ___________________ Subscriber Employer: ________________________

Insurance Company Name: ____

Insurance Company Address:____

Insurance Company Phone: ___________________ Group Number:_______________________

Insurance – Secondary

Subscriber Name: _________________Relationship to Patient: ________ Subscriber DOB: ________

Subscriber SSN/ID: ___________________ Subscriber Employer: ________________________

Insurance Company Name: ____

Insurance Company Address:____

Insurance Company Phone: ___________________ Group Number:_______________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Palos Pediatric Dentistry, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____________________ Relationship: ___________ Date: _________

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:____