Medina Pediatric Dentistry

REGISTRATION FORM

Today's Date:	Primary Medical Doctor:

PATIENT INFORMATION

Patients Last Name : First: Middle:	Patient's Social Security #

Parent/Guardian Name: Date of Birth(parent):	Address of Parent/ Guardian :	Patients Birth date:	Sex: ☐ M ☐ F

Social Security(parent)	Home phone #:	Cell phone #:
Parent/ Guardian Occupation:	Parent / Guardian Employer:	Emergency Number : /Name :

How did you hear of our practice: _____ Has the patient ever seen any other Dentist for Dental Care: _____

Were you referred to our practice? _____ If so, name of other Dentist: _____

ARE OTHER family members seen here?:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.) If patient has a government insurance they are the policy holder

Person responsible for bill:	Birth date:	Address (if different):	Home phone #:
Do you have an email address? yes or no	Email Address	Is this patient covered by insurance?	☐ Yes ☐ No
Occupation:	Employer:	Employer Phone #	Name of Insurance Company:

Please indicate primary insurance: (1st) Member/Subscriber Id #

Subscriber's name:	Subscriber's S.S. # :	Birth date:	Group #. :	Policy # :	Co-payment: $

Patient's relationship to subscriber: | Other:

Name of secondary insurance(2nd) (if applicable):	Subscriber's name:	Member/Subscriber#	Group #

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone # :	Work phone # :

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Medina Pediatric Dentistry or insurance company to release any information required to process my claims.

Patient/Guardian signature Date