## Medina Pediatric Dentistry

# **REGISTRATION FORM**

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| **Today’s Date:**  | **Primary Medical Doctor:**  |

PATIENT INFORMATION

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|  | **Patients Last Name : First: Middle:**  | **Patient’s Social Security #**  |  |

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| **Parent/Guardian Name:**  | **Address of Parent/ Guardian :**  |  |  **Patients Birth date:** |  | **Sex:** |
| **Date of Birth(parent):**  |  |  |  |  |  |
| **Social Security(parent)** | **Home phone #:**  | **Cell phone #:** |
|  |  |  |
| **Parent/ Guardian Occupation:** | **Parent / Guardian Employer:** | **Emergency Number : /Name :** |
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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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**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**

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| **Person responsible for bill:** | **Birth date:** | **Address (if different):** | **Home phone #:**  |
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| **Do you have an email address? yes or no**  | **Email Address**  | **Is this patient covered by insurance?** |  |
| **Occupation:** | **Employer:** | **Employer Phone #**  | **Name of Insurance Company:** |
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**Please indicate primary insurance: (1st) Member/Subscriber Id #**

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| --- | --- | --- | --- | --- | --- |
| **Subscriber’s name:** | **Subscriber’s S.S. # :** | **Birth date:** | **Group #. :** | **Policy # :** | **Co-payment:** |
|  |  |  |  |  | **$** |

**Patient’s relationship to subscriber: | Other:**

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| **Name of secondary insurance(2nd) (if applicable):** | **Subscriber’s name:** | **Member/Subscriber#**  | **Group #**  |
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**Patient’s relationship to subscriber:** **IN CASE OF EMERGENCY**

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| --- | --- | --- | --- |
| **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.**

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|  | **Patient/Guardian signature** |  | **Date** |  |

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