## Medina Pediatric Dentistry

# **REGISTRATION FORM**

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| |  |  | | --- | --- | | **Today’s Date:** | **Primary Medical Doctor:** |  PATIENT INFORMATION  |  |  |  |  | | --- | --- | --- | --- | |  | **Patients Last Name : First: Middle:** | **Patient’s Social Security #** |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **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 :** | | | | |  | |  | | |  | | | |  |  | | --- | | **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?** |  | | **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** |  | |
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