PEDIATRIC DENTAL ASSOCIATES, LLC

Minor Patient Registration

***FULL LEGAL NAME* OF THE PATIENT:**

First Name: _____ M.I._____ Last Name: _____

Name child would prefer we use? _____ Age: _____ Date of Birth: _____/_____/_____

Male / Female SSN# _____-_____-_____ Referred by: _____

Sibling names:_____ E-mail:_____@_____._____

Name(s) of Custodial Parent?_____ Legal or Physical or Both ← ***circle one***

FULL LEGAL NAME* OF:** Male / Female ***circle one below

Biological Adoptive Foster Step parent Legal Guardian

First Name: _____ M.I. _____

Last Name: _____

Physical Address: _____

City _____ State _____ Zip _____

Mailing Address: _____

City _____ State _____ Zip _____

Home#: ____-____-_____ Work#: ____-_____-_____

Cell#: ____-_____-_____ Other#: ____-_____-_____

Date of Birth: ____-_____-____ SSN#: _____-_____-_____

Driver's License/ID # _____ State _____

Employer: _____

Occupation: _____

Married / Divorced / Widowed / Single / Other_____

Name of Spouse:_____

FULL LEGAL NAME* OF:** Male / Female ***circle one below

Biological Adoptive Foster Step parent Legal Guardian

First Name: _____ M.I. _____

Last Name: _____

Physical Address: _____

City _____ State _____ Zip _____

Mailing Address: _____

City _____ State _____ Zip _____

Home#: ____-____-_____ Work#: ____-_____-_____

Cell#: ____-_____-_____ Other#: ____-____-_____

Date of Birth: ____-_____-____ SSN#: _____-_____-_____

Driver's License/ID# _____ State_____

Employer: _____

Occupation: _____

Married / Divorced / Widowed / Single / Other_____

Name of Spouse:_____

***EMERGENCY CONTACT:** *(Someone outside your household who could help us contact you.)*

Name: _____Hm #:_____-_____-_____ Cell#: _____-_____-_____

- I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform Pediatric Dental Associates LLC of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need, once I have been informed.
- I will inform Pediatric Dental Associates LLC of any change in my child's health and/or medications, family information, financial responsibly, or insurance coverage. I will not hold Pediatric Dental Associates LLC or any of its Doctor's staff members responsible for any errors or omissions that I may have made in completion of this form.
- I agree to comply with this office's Financial and Appointment Policy and am aware a copy is available upon my request.

_____ _____ _____/_____/_____

Responsible Party's name Responsible Party's signature Date